The Dissertation Committee for Ogechukwu Christiana Ezekwem Certifies that this is the approved version of the following dissertation:

Contested Spaces: Culture, Faith, and Childbirth in Nigeria, 1900 to 1960

Committee:

Oloruntoyin Falola, Supervisor

Abena Dove Osseo-Asare

Juliet Walker

Philippa Levine

Gloria Chuku

Contested Spaces: Culture, Faith, and Childbirth in Nigeria, 1900 to 1960

by

Ogechukwu Christiana Ezekwem, B.A., M.A.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

May 2017

Dedication

To my late mother, Mrs. Helen Ezekwem

Preface

As a youth corps member in Northern Nigeria, I volunteered as a Peer Education Trainer in the National Reproductive Health and HIV/AIDS Scheme for a year. The project provided tutoring sessions and workshops for women living with HIV/AIDS. It also involved signing up with a high school as an academic and reproductive health mentor. At this time, I observed the disconnect between interventions on reproductive health and people's cultural and religious beliefs. This experience generated questions about maternal and infant mortality rates in the North and led to the conceptualization of a project on childbirth. My research questions revolve around understanding the reproductive traditions operational in Nigeria and the historical process of "othering" non-biomedical birthing institutions. This project is, therefore, an account of medical pluralism in which various therapeutic cultures thrived in the same space, often in contention and constant negotiations with each other. Continuity and change happen concurrently in this historical account of midwifery.

Since this work is the first comprehensive study of childbirth in Nigeria, the chapters in this dissertation provide a historical analysis of Nigeria's maternal health systems. It does not address the question of current challenges, but lays sufficient background for interpreting them. The study spans from 1900 - the beginning of formal British colonial rule in Nigeria - to independence in 1960. The various chapters are

organized thematically. Chapter one provides an overview of traditional, biomedical, and faith-based midwifery in Nigeria, and offers some analyses of terms that I use or desist from using in my representation of local childbirth. It also places this study within a broader framework. Chapter two discusses traditional birthing practices prior to 1960, with a case study from the Igbo of southeastern Nigeria. It frames the discussion of local birthing norms and outcomes within the framework of the cultural concept of motherhood. Chapter three focuses on the onset of medical missions and the establishment of biomedical maternities across Nigeria. This period marked the transition to hospital birth and the development of a professional cadre of midwives. Following missionary antagonism of local converts and the waves of epidemics that hit Western Nigeria, an indigenous Christian movement emerged in the region in 1929, leading to the creation of faith-based birthing institutions. Chapter four discusses this indigenous religious movement - the *Aladura* Movement - and the onset of faith delivery homes. The narrative revolves around one of the earliest *Aladura* churches, Christ Apostolic Church (CAC). Chapter five considers the clashes between traditional, biomedical, and faith-based birthing institutions, and the new identities formed as a result. It discusses the impact of class, religion, and urbanization on birthing decisions, the emergence of herbal-maternity homes and private maternities, and the introduction of domiciliary midwives by the colonial government. New medico-cultural objects were also adopted to join prior local representations of birth. The epilogue connects this historical study to post-independence trends in midwifery, such as the post-colonial state's birth control politics

and the initiation of safe motherhood programs. It also reflects on the challenges of midwifery in post-colonial Nigeria.

Acknowledgements

Since the conception of this project, several people have contributed immensely to its success. I first turn to members of my dissertation committee, without whom this project would have taken a different form. I can confidently state that I have the dream committee! My gratitude goes to Prof. Toyin Falola who has been with me every step of the way. I felt his guidance from the moment I scribbled my first ideas until now. The conversations we've had from his office to his car, after his office hours, have been some of the most career-defining ones. I am glad that he let me tag along and pester him with more questions than he was ready to deal with. I appreciate the relentless support.

Dr. Abena Osseo-Asare was my "powerhouse" throughout this dissertation research and writing process. We shared many conversations about versions of my chapters and sources, and every visit to her office was a source of motivation. Thank you for going through my multiple drafts and ideas. No less was the support that I received from Prof. Philippa Levine long before I began research for this project. I was fond of stopping by her office before any research trips, and made sure to have pen and paper in tow. Our conversations led me to some of the archives that I visited in the United Kingdom. To Prof. Juliet Walker, I also owe a lot of thanks. She motivated me to always think of my work in broader terms and draw parallels with occurrences in the African diaspora. I appreciate her patience with me through the days that I visited her office almost every week and would sit there just before her office hours, waiting for her to arrive. I now turn to my external committee member, Prof. Gloria Chuku, to whom I am grateful for her contributions to my project. I had met Prof. Chuku at the University of Nigeria in 2007. She was conducting research at the departmental library and I was the

departmental librarian. I admired her a lot (then and now), and was pleased when she accepted to be on my committee. Her in depth analytical insight shaped my dissertation proposal and prospectus, and was instrumental in the final revisions to my prospectus during the early research stages.

Several people made my field research seamless. First is Dr. Chukwuma Opata who accompanied me to several interviews, drove me to some of the remote locations, and introduced me to many interviewees. I am grateful to him for his time and efforts. My friend, Ijeoma Ezenwuba, also turned into my personal chauffer during moments when I could secure no type of mobility to several of my locations. Similarly, Emmanuel Chukwuneke and I have been to many interviews together, especially those that involved travel into interior communities around Nsukka. On several occasions, he arranged for accommodation with local residents for me. Emma was a part of this project from the early days when it was just an idea and I barely knew where I was headed with it. I thank him for his many intellectual and social contributions to my project. One could never ask for a truer friend.

During my research in Ibadan, I met some of the most wonderful people. It was my first trip to this city, and I was a stranger to everything. I had been to Lagos, a Yoruba city (though cosmopolitan), but nothing prepared me for Ibadan. I went through some culture shock before I finally settled in. During this trip, two beautiful souls made my research productive. Mama Sewa and Mama Dami organized some of my interviews and accompanied me to some of the locations. Despite the economic downturn and fuel scarcity in Nigeria at the time, Mama Sewa queued for gas, secured the elusive commodity, and came rushing over to my hotel room to ensure that I attended one interview or the other. Her step daughter, Adunni Adelakun, who is also a dear friend,

had introduced us remotely, and that was all Mama Sewa needed to assist me in every way that she could. I cannot express how grateful I am for the many times that she drove me from one corner of Ibadan to the other. In this lens, I also thank Emmanuel Ogungbemi, who attended countless interviews at several Christ Apostolic Churches with me, and who translated back and forth when I could not understand statements by the interviewee and vice versa. Emmanuel made time from his busy school schedule to help me in any way that he could. My gratitude also goes to Dr. Omobowale of the University of Ibadan for introducing me not only to Emmanuel but to other Medical Anthropology students who assisted me in different forms. Similarly, I appreciate Dr. Adebowale Ayobade for connecting me with Dr. Omobowale and other contacts at Ibadan who made my experience productive.

To everyone who has read versions of this dissertation, dissertation proposals, and other similar essays, thank you. I especially give a shout out to Cacee Hoyer and Shery Chanis whose unflinching support has been tremendous for me from the days when this project was merely an idea. I cannot count the number of draft proposals that they have read. In this regard, I also thank members of the History department's dissertation colloquium for the many draft proposals and abstracts that they have read and discussed. I appreciate Dr. Alison Frazier for organizing this forum and providing this opportunity for peer review and feedback. We all certainly learned from each other.

I could not have gone through this academic journey without the support of my parents, Chief John and Late Mrs. Helen Ezekwem. Thank you for your dedicated support. My uncle and aunt, Mr. and Mrs. Pius and Esther Ezekwem always kept their house open to me as I traveled back and forth through Lagos on my research trips.

I now turn to my husband, Adam Williams, whose goodwill helped me through this whole process. He supported my extended research trips and provided a conducive space for me to work, especially during those moments with impossible deadlines. He also ensured that I stayed healthy, constantly nudging me to step outside for “fresh air,” spend more time in the sun, and other such admonitions. He made it his responsibility to ensure that I stayed balanced and participated in other activities outside of school and the dissertation. Thank you for tolerating my academic self, and for being my most ardent supporter.

This is no exhaustive vote of thanks, and I appreciate everyone who has contributed to this project in any way. *Daalu nu* (Thank you).

Contested Spaces: Culture, Faith, and Childbirth in Nigeria, 1900 to 1960

Ogechukwu Christiana Ezekwem, PhD

The University of Texas at Austin, 2017

Supervisor: Oloruntoyin Falola

Drawing from oral traditions, colonial files, Christian missionary records, and museum artifacts, my dissertation examines the shifts from traditional midwifery to hospital births and faith-based birthing homes in colonial Nigeria. I study the interactions between these three birthing cultures and how the tensions that ensued among them shaped the reproductive sensibilities that pervaded Nigeria at independence. I analyze the moments when women became objects of the colonial medical gaze - as instruments of evangelism for missionaries and health propaganda tools for the colonial administration. I also examine the emergence of the *Aladura* Movement, a religious movement that developed in Western Nigeria in 1929 and culminated in the creation of birthing institutions separate from and hostile to traditional medicine and biomedicine. Through a socio-cultural lens, my dissertation highlights the use of medicine as a form of resistance and indoctrination among colonized populations. It challenges a historiographical tradition that studies traditional, biomedical, and faith-based childbirth in isolation. By evaluating these modes of childbirth jointly, it offers a comprehensive view of the religious and socio-political dynamics that molded Nigeria's reproductive landscape, and the importance of medical pluralism in attaining a sustainable health care model. My dissertation is the first

comprehensive study of midwifery in Nigeria. It offers an important historical context to the lackluster reception, especially in official circles, towards non-biomedical birthing institutions.

Table of Contents

List of Tables

List of Figures

Chapter One

The Different Faces of Childbirth: An Introduction

Introduction

While childbirth is ordinary and universal, it is experienced differently among various cultures. For early missionaries, traditional midwifery in Nigeria throughout the colonial era was categorized as "dangerous midwifery;" yet, this was not a reflection of the midwife's skills but stemmed from the missionaries' inability to understand the purpose of culturally specific birthing practices. This is akin to the way that a Nigerian from the early twentieth century might describe English birth during that century. Birthing on a hospital bed, as obtained in England, would have been interpreted as against the natural order in which babies moved downward during birth. A standing or kneeling position, which aided the baby's downward pressure on the perineum, was instead considered safer. Church Missionary Society reverend, G.T. Basden, describes the reaction of locals to a missionary who laid her baby in a crib in the early 1900s:

> [This] raised grave doubts as to whether she cared for her child. To put the baby "upon a shelf" as if it were a common utensil, was utterly

> incompatible with the local ideas of affection. To neglect the child thus showed a complete want of love, and a scant respect even for duty.[1]

The Igbo people, whose reactions Basden recounts, had babies sleep with their mothers. This missionary's act was, therefore, interpreted as "dangerous childrearing." This story highlights the importance of understanding practices on their own terms and within particular cultural settings. Notwithstanding, cultures change as they encounter external forces and new technologies. This was the situation in colonial Nigeria at a time when missionary tactics threatened traditional birthing institutions and inadvertently gave rise to indigenous faith-based birthing homes.

Some of the key questions that this study explores include: What types of birthing institutions existed in colonial Nigeria? What is the nature of the relationship between these institutions? Did their interactions or existence within the same space result in the creation of other unique or hybrid institutions? *Contested Spaces* is a historical study of the transitions from traditional midwifery to hospital birth and faith delivery homes, and the subtle negotiations between these birthing cultures. It highlights the impact of these diverse medico-cultural encounters on reproductive trends in Nigeria at independence in 1960. It is an account of birthing practices, taboos, and adaptations. As the colonial era

---

1 G. T. Basden, *Among the Igbo of Nigeria* (Gloucestershire: Nonsuch Publishing Limited, 2006), 53.

unfolded, missionaries introduced biomedical birthing institutions in Nigeria, undermining local practices. By 1930s, *Aladura* churches (a set of independent African churches), arrived on the colonial scene, introducing their own principles of medicine and childbirth and initiating a contentious relationship between them, the mission hospitals, and traditional practitioners.

Amidst the joint existence of the trio, there emerged a culture of hybridity and adaptation. *Contested Spaces* evaluates these moments when developments in one birthing institution affected the changes that occurred in the other. The traditional practitioner, whose patrons were responding to urbanization and Christianity, adapted by learning some biomedical techniques. Similarly, the *Aladura*, whose members now consisted of doctors and nurses and who were subjected to harassments from the government, eased up on their non-tolerance to biomedicine. Hospitals were not left out in this hybridity. As the demand for midwifery services increased across the country and more people embraced prenatal services while birthing at home with their midwives, colonial and missionary agents introduced domiciliary midwifery, modeled after the traditional midwife. This dissertation explores the intersections between these intricate relationships and how they shaped Nigeria's midwifery sector at independence. Its premise is that childbirth was a constant site of bargaining and hybridity. Though missionaries sought to replace a system that was considered backward, what emerged mostly were refashioned syncretic practices that embodied the old and the new.

Contested Spaces defies a historiographical tradition that studies different birthing philosophies separately. These birthing cultures did not exist in a vacuum but influenced each other in attempts to remain relevant, hence the importance of a comparative approach. Throughout the 1950s, colonial midwifery constantly adjusted to local circumstances. The Midwifery Board introduced the community nurse whose services mimicked that of the traditional midwife and included home visits and childcare. Since community nursing appealed to local circumstances, local governments applied to sponsor candidates in lieu of five-year contracts. Traditional midwives, on the other hand, attached themselves to trained nurses and learned some relevant biomedical practices while some *Aladura* churches adjusted their absolute condemnation of biomedicine as sinful. Trained midwives with knowledge of traditional midwifery combined the two methods in their maternity homes. These nuances of subtle negotiations cannot be unraveled if traditional and biomedical birthing methods are studied separately.

Unlike existing historiography on childbirth in Africa, *Contested Spaces* considers the distinct religious birthing spaces created by African Independent Churches (AICs) in opposition to biomedical and traditional medicine. AIC birthing homes arose in Western Nigeria at a time of severe disease outbreaks and animosity against western Christian missions who relegated Africans to lower church ranks. Studying this generally ignored aspect of birthing in the historiography of African midwifery brings to the fore the extent of their influence on maternal and childcare and the importance of their inclusion in local and international maternal health initiatives. Religious movements similar to the one that

produced faith delivery homes in Nigeria also occurred in various parts of Africa, for instance, South Africa, Ivory Coast, and Congo. It is important that discourses on childbirth examine these institutions and their impact on reproductive trends across Africa. Faith delivery homes have become a permanent feature of Nigeria's reproductive scene. They serve a significant population in Western Nigeria, especially because they are cheaper alternatives to hospital births. Also, they catered to the spiritual, physical, and psychological aspects of childbirth, unlike their hospital counterparts. Yet, they are not part of the national or international dialogue on maternal healthcare. This form of maternal care appeals not only to Christians but also Muslims, in a country that is constantly divided along religious lines.

Contested Spaces is the first comprehensive historical study of childbirth in Nigeria. It creates a connection between midwifery in colonial Nigeria and the contemporary challenges of childbirth and maternal health interventions in the post-independence era. According to UNICEF, Nigeria's maternal and infant mortality rate is the second largest in the world.[2] Contributors to these statistics include the unfavorable attitudes to biomedical forms of childbirth, which form the bulk of maternity care for rural communities, and government disinvestment in healthcare. The neglect of faith delivery homes, a crucial birthing resource in some parts of Nigeria, during health outreaches compounds these setbacks. This study, therefore, links the historical

---

[2] UNICEF, "Maternal and Child Health," Available: http://www.unicef.org/nigeria/children_1926.html, accessed August 2014.

developments in maternal welfare to contemporary challenges of maternal and childcare in the postcolonial era and how the combined application of various maternal health approaches can ameliorate present circumstances.

On Childbirth and Three Institutions: The Beginning

In 2013, a retired traditional midwife reminisced about her experiences as a midwife fifty-five years earlier, as we sat outside an old building made of mud and cement. Across the building was a simple and unpainted two-bedroom house with wooden doors and windows. It used to be her birthing home. She added this house to her compound when it became the practice for an expecting mother to birth and receive early care in her midwife's home rather than in her own compound. This was part of the wind of change that colonialism brought. This facility was no longer in use, but it represented a moment in the evolution of midwifery in Nigeria. Its matron, who welcomed me with reluctance, represented an era when midwives attempted to refashion their practices to changing circumstances in a colonial and urban landscape.

The midwife, Mary, came from a line of midwives; her mother and grandmother had been midwives too. It was she who experienced all the changes and adjustments that hit traditional medical practitioners from the mid colonial era and beyond. She participated in efforts to compete with hospitals and their medicalized births. She recounted stories of her participations in the Nigerian Union of Medical Herbal Practitioners, an organization formed to stave off bullying by the government and the

police, and make traditional medicine more legitimate. She still had her worn certificate of membership in the organization and displayed this for me to see. On her memories of hospital births, Mary recounted how she walked into a hospital and witnessed a young nurse addressing a woman in labor in a discomforting manner. She rebuked the nurse sharply and explained:

> "you do not address a woman in labor in such manner. You should treat her with care and soothe her with comforting worlds. In a moment like this, she is in between worlds…that of the living and the dead. These new brands of midwives do not recognize that. I don't understand what they are taught. Well, they haven't even had their own babies. I wanted to slap the stars out of that girl's eyes."[3]

In the old times, after all, only women who had experienced childbirth could become midwives, but that was not the case in the new order.

---

3 Mary Ugwuanyi, c.89, Obollo Road, Nsukka, June 26, 2013.

Figure 1: Mary's Certificate of Membership for the National Union of Medical Herbal Practitioners

Mary had refused to grant me audience, unless I paid a stipulated and rather sizable sum of money. She could not understand that I was just a researcher attempting to write a project on childbirth. To her, I was just another midwifery student in one of these "big schools" trying to harness knowledge of local methods. She had received many inquirers from midwifery schools and began to charge a fee for her instruction. This misunderstanding of my objective was not unique to Mary, though hers shocked me the most because of her insistence that I pay a fee, and her unflinching belief that I was a

midwife-in-training. She was my first interviewee. Two years later, most of the older women that I interviewed punctuated our sessions with admonition to be "selfless and strong-hearted," as this was the greatest quality needed in a midwife. I abandoned my unheeded explanations that I was merely a researcher. The experience with Mary, who apprenticed with a trained nurse in the 1950s and joined a herbal association in the bid to stay competitive, shaped some of my early research questions. The first was an attempt to figure out exactly what traditional midwifery entailed. The second question, which ties my research together, considered the interactions and negotiations between traditional, biomedical, and faith-based midwifery.

Efforts to understand faith-based midwifery came much later in this research. The focus in 2013 was on traditional midwifery, missionary medicine, and the shift to hospital birth. Missionaries, who were the traditional practitioners' greatest contenders, provided the bulk of medical care in Nigeria's early colonial period. This was both philanthropy and an evangelical tactic. Missionaries viewed traditional medical practitioners as a bastion of evil, backwardness, and ungodliness. Female missionaries targeted local women as the key to evangelizing households and communities, and the best way to reach them was during childbirth, when they were extremely vulnerable. For me, the question that remained was: from where did the initial efforts to Christianize childbirth emanate? A look at the Cadbury Research Library at the University of Birmingham and the Nigerian National Archives, Enugu shed some light on this question. Some files spoke of pioneering works at the Onitsha Medical Mission, part of the CMS's Niger

missions.[4] These documents spoke of Iyi-Enu Hospital, whose history dated back to 1897. It was there that many practices of missionary maternity were developed and spread across the country. I knew this hospital. It still belonged to the Anglican church and is located in Ogidi, close to Onitsha, the commercial hub of colonial and post-colonial eastern Nigeria. My research now took me to this hospital, which I had passed many times in the past, and where I had visited my grandmother as a young girl.

Figure 2: Iyi-Enu Hospital, Ogidi 2016

[4] During these earlier years, up to 1908, Northern Nigeria was also classified as part of the Niger Mission.

Figure 3: Old Chapel from the colonial period still standing, 2016

Some of Iyi-Enu's old structures still stood whereas others had been renovated or replaced by larger edifices. The Dobinson Memorial Hall - Iyi-Enu's earliest building and the first permanent maternity structure and theatre - still stands in its original form, though it has seen several modifications. This hospital has since expanded into a large mission hospital that serves as a base for contemporary medical missionaries. Early female missionaries, such as Mary Elms and Dorothy Ross, worked out of this location to promote maternity. From Iyi-Enu, ideas such as Baby Shows and Health Weeks became popular and widespread across the country. In its earlier history, people trekked many miles to visit the hospital, the only major mission facility in the area. Patients visited it

from as far as Northern Nigeria. Professional maternity work as an instrument of evangelism also yielded its fruits here, from where it spread across the country.

Missionary policies in Nigeria stirred a different kind of indigenous religious-medical movement based on faith healing. The search for faith delivery homes took me to Talafia, Ede in Western Nigeria. Here, I saw the first Faith Home, built in 1959. This old building represented the history of faith delivery homes in Nigeria. It was a center for spiritual healing and the training of *Aladura* midwives. It was dedicated to the care of pregnant women. Since the foundation of this Faith Home, faith delivery homes became permanent features of *Aladura* churches. Selected midwives manned these facilities and received training, where possible, at this pioneer faith home in Ede. These homes provided philanthropic services to women of all faith as long as they registered with the church midwife between the third to fifth month of their pregnancy. They were required to attend mandatory weekly prayer services for expecting mothers. *Aladura* midwives remain prominent actors in the provision of maternal care, especially in Western Nigeria.

Figure 4: The old Faith Home in Talafia, Ede, built in 1959

Cultural systems influence experiences of health and medical care. These encounters change as cultures adapt. Local norms continued to impact each birthing philosophy in Nigeria. Syringes and tablets were adopted into the local imagination as signifying authentic healing while water, for the Aladura, retained its role as a symbol of healing in the local religious system. The old and new blended into one.

The Concept of Medical Pluralism

Various studies of medicine have utilized the term, medical pluralism, to explain the diverse avenues of healing that exists in any medical landscape. Scholars like Roy Porter describes medical practices as embodying a significant variety, “with learned or

scientific medicine existing alongside popular or folk traditions, irregular or alternative medicine, as well as 'quackery'."[5] Other scholars emphasize that traditional medical practices not only exist alongside western medicine but engage in competition with it.[6] The relationship between the three birthing traditions in this study embodies such competition. The various practices did not have separate clienteles but, instead, employed tactics to gain a foothold among the locals, who in turn matched the therapies in ways that promised better outcomes. Missionaries, in fact, complained that the *Aladura* Movement which began in 1929 emptied their hospitals as people sought for quick and effective modes of healing and fertility (see chapter 4). The missionaries' call for more doctors and nurses were a direct response to this competition. They feared, not only that

---

5 Roy Porter (ed.), *The Popularization of Medicine, 1650-1850* (London: Routledge, 1992), 1.

6 Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley: University of California Press, 1980); V. Sujatha and Leena Abraham (eds.), *Medical Pluralism in Contemporary India* (India: Orient Blackswan, 2012); R. Cooter, *Studies in the History of Alternative Medicine* (Houndsmill: Macmillan, 1988); Projit B. Mukharji, *Doctoring Tradition: Ayurveda, Small Technologies, and Braided Sciences* (Chicago: The University of Chicago Press, 2016); David Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Charles Leslie and A. Young (eds.), *Paths to Medical Knowledge* (Berkeley: University of California Press, 1992).

the *Aladura* took away their patients but also provided another alternative and free type of therapy than mission hospitals could offer.[7]

Contested Spaces is an account of the intersections between different modes of childbirth and how their coexistence resulted in the creation of new traditions. As this research unfolded, it became clear that traditional, biomedical, and faith-based birthing institutions existed in plural forms, both for the clientele and the institutions. Expecting mothers and their families infused local and cultural norms associated with childbirth into the hospital setting. By the 1950s, when hospitals were manned predominantly by local people, the biomedical space became increasingly layered with local contexts of health and illness, and practices that followed local norms. Traditional and faith-based midwives, on the other hand, integrated aspects of biomedical care that suited their needs. Syringes and tablets became incorporated into the traditional midwife's healing accoutrement while the faith-based midwife adopted some practical trainings of biomedicine as well as adjusted their antagonistic view of member's participation in biomedical and traditional medical spaces. Traditional midwives also created avenues through which they learned and utilized biomedical patterns. From the 1940s, traditional midwives adopted permanent structures, known as birthing homes, where childbirth

---

[7] In chapter 4, I point out that people turned away from paying the fees gradually imposed by hospitals, where possible.

occurred. The traditional birthing space now shifted from the expecting mother's home or that of her older relatives to the midwife's birthing home.

A core question that medical pluralism addresses, and one which this study grapples with, is the notion of clear demarcations between different medical systems. One major argument in this dissertation is that maternal medicine, in its traditional, religious, and biomedical form, were constant sites of negotiations and contests. Their mostly contentious relationships resulted in remolded traditions and in some instances the invention of new "traditions." Tradition is after all not rigid but created and sometimes reinvented as societies encounter external forces and other forms of interactions. Medical traditions, according to Waltraud Ernst, "are intrinsically plural – both in terms of the variety of ways in which any one tradition has been interpreted and codified by different learned authorities, and in terms of the great variety of their practical applications."[8] This definition is exemplified in the relationships between colonial maternities, traditional midwives, and faith homes. In this study, continuity and transformation occur simultaneously.

---

8 Waltraud Ernst, "Plural Medicine, Tradition, and Modernity. Historical and Contemporary Perspectives: Views from Below and from above," in *Plural Medicine, Tradition, and Modernity, 1800-2000*, edited by Waltraud Ernst (London: Routledge, 2002), 6.

Literature Review

Contested Spaces engages Megan Vaughan's *Curing their Ills*, a seminal work on colonial medicine.[9] Through a discussion of biomedicine, Vaughan analyzes Africans' objectification under colonial biomedicine. Her work raises important issues regarding imperial governments' approach to medicine. She observes that the involvement of Africans in colonial biomedical discourses does not necessarily mean compliance but sometimes a path to creating new identities. This idea resonates with my argument that local adaptations to colonial midwifery involved shades of negotiations, subtle resistance, and class arrangements. Likewise, Beverly Chalmers' *African Birth* discusses the influences of colonial medicine on local notions of childbirth in South Africa, though he does not incorporate the colonial birthing institution in any detail nor explore the influences of indigenous practices on colonial maternities.[10] Hibba Abuigideiri's study of Egypt provides insight into the transition to modern medicine in Egypt and the importance of studying indigenous and western medical systems in comparison.[11]

---

9 Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Polity Press, 1991).

10 Beverley Chalmers, *African Birth*: *Childbirth in Cultural Transition* (South Africa: Berev Publications CC, 1990).

11 Hibba Abugideiri, *Gender and the Making of Modern medicine in Colonial Egypt* (Burlington: Ashgate Publishing Company, 2010).

Missions, States, and European Expansions in Africa also offer accounts of missionary interventions in Africa.[12] These works point to the importance of understanding the ways that African birthing systems have evolved as well as how they are integrated into modern medicine.

Of greater importance to any study of childbirth in Africa is Nancy Hunt's work on colonial childbirth in the Congo.[13] Though her focus is not the interactions between traditional and biomedical birthing institutions, she offers a complex narrative of colonial and missionary maternities as well as the occasional moments of collaboration between a traditional midwife and missionaries. Her research emphasizes the invaluable place of Christian missions in the construction of colonial birthing institutions. Mercy Oduyoye and Musimbi Kanyoro's edited volume on women in Africa focus on the church's impact on African rituals. Some chapters discuss purification rites and birthing rituals performed at the onset of pregnancy up to childbirth.[14] Helaine Selin and Pamela Stone's work on childbirth in different parts of the world offers limited accounts on traditional midwifery

---

12 Chima Korieh and Ralph Chijioke Njoku (eds.), *Missions, States, and European Expansions in Africa* (New York: Routeledge, 2007).

13 Nancy Rose Hunt, *Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999).

14 Mercy Amba Oduyoye and Musimbi R. A. Kanyoro (eds.) *The Will to Rise: Women, Tradition, and the Church in Africa* (New York: Orbis Books, 1992).

but provides detailed examples of current practices of midwifery and the challenges of childbirth in contemporary Africa.[15]

Karen Flint's study of African healers' adaptations in South Africa's multicultural society offers a methodological influence on my project. Through her interrogation of the term, "tradition," she highlights the colonial and anthropological construction of this concept to depict African practices as static and primitive.[16] It was not until the 1980s that Jan Vansina, a historian and anthropologist, successfully repudiated this approach to African traditions and instead depicted it as dynamic and adaptable to external influences. Flint's discussion of the colonial construction of "tradition" influences the ways that I treat the term in my own research and my wariness about the origins and application of imperial-constructed categories. Similarly, Stacey Langwick's description of Tanzanians' interpretation of the terms Traditional Birth Attendants (TBAs) and "traditional" midwife

---

15 Helaine Selin and Pamela Stone (eds.), *Childbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth, and Post-Partum* (New York: Springer Dordrecht Heidelberg, 2009). B.T. Nasah, J.K.G. Mati and J.M. Kasonde (eds.), *Contemporary Issues in Maternal Health Care in Africa* (Luxembourg: Hardwood Academic Publishers, 1994) also focus on contemporary challenges of birthing in Africa.

16 Karen Flint, *Healing Traditions: African Medicine, Cultural Exchanges, and Competition in South Africa, 1820-1948* (Ohio: Ohio University Press, 2008).

make me conscious of the complications surrounding branding and how the brander and branded may understand terms differently.[17]

Other works on medical pluralism also offer theoretical influences on this study. Like Flint's work, Mukharji's *Doctoring Traditions* points out the complexities of the terms "tradition" and "modern" and how traditional medical systems are infused with symbols or instruments from modern practices. His book focuses on how modern Ayurveda was produced through the "braiding of 'West' and 'East' around material objects and ideas."[18] Ernest's *Plural Medicine* also highlights the impacts of cultural representations on medical systems and how medical traditions are a result of negotiations and contests among various actors at particular moments.[19]

Contested Spaces also extends the conversation on African Independent Churches, which has long revolved around the church politics and gender dynamics.[20] By

---

17 Stacey Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Bloomington: Indiana University Press, 2011), 121-150.

18 Mukharji, *Doctoring Traditions*, 2.

19 Ernst, *Medical Pluralism*.

20 J.D.Y. Peel, *Aladura: A Religious Movement Among the Yoruba* (London: Oxford University Press, 1968); Harold Turner, *History of an African independent Church* (Oxford: Clarendon Press, 1967); Brigid Sackey, *New Directions In Gender and Religion: The Changing Status of Women in African Independent Churches* (Lanham:

emphasizing the separate institutions of healing that they created, notably their birthing services, it opens a conversation on the social and philanthropic component of these churches, and adds to the literature on AIC doctrines, politics, and organization. Two important works by J. D. Peel and Harold Turner provide the earliest studies on the *Aladura* in Nigeria.[21] Turner focuses specifically on one of the first *Aladura* churches, The Church of the Lord-Aladura, while Peel offers a more general history of the *Aladura* movement. A later publication by Helen Crumbley offers a gendered perspective to *Aladura* churches.[22]

Lexington Books, 2006); Ane Marie Bak Rasmussen, *Modern African Spirituality: The Independent Holy Spirit Churches in East Africa, 1902-1976* (London: British Academic Press, 1996); Frederick Welbourn, *East African Rebels: A Study of Some Independent Churches* (London: SCM Press, 1961); Isabel Mukonyora, *Wandering a Gendered Wilderness: Suffering and Healing in an African Initiated Church* (New York: P. Lang, 2007).

21 Peel, *Aladura: A Religious Movement Among the Yoruba*; Turner, *History of an African independent Church.*

22 Deidre Helen Crumbley, *Spirit, Structure, and Flesh: Gendered Experiences in African Instituted Churches among the Yoruba of Nigeria* (Madison: University of Wisconsin Press, 2008).

Background of Study

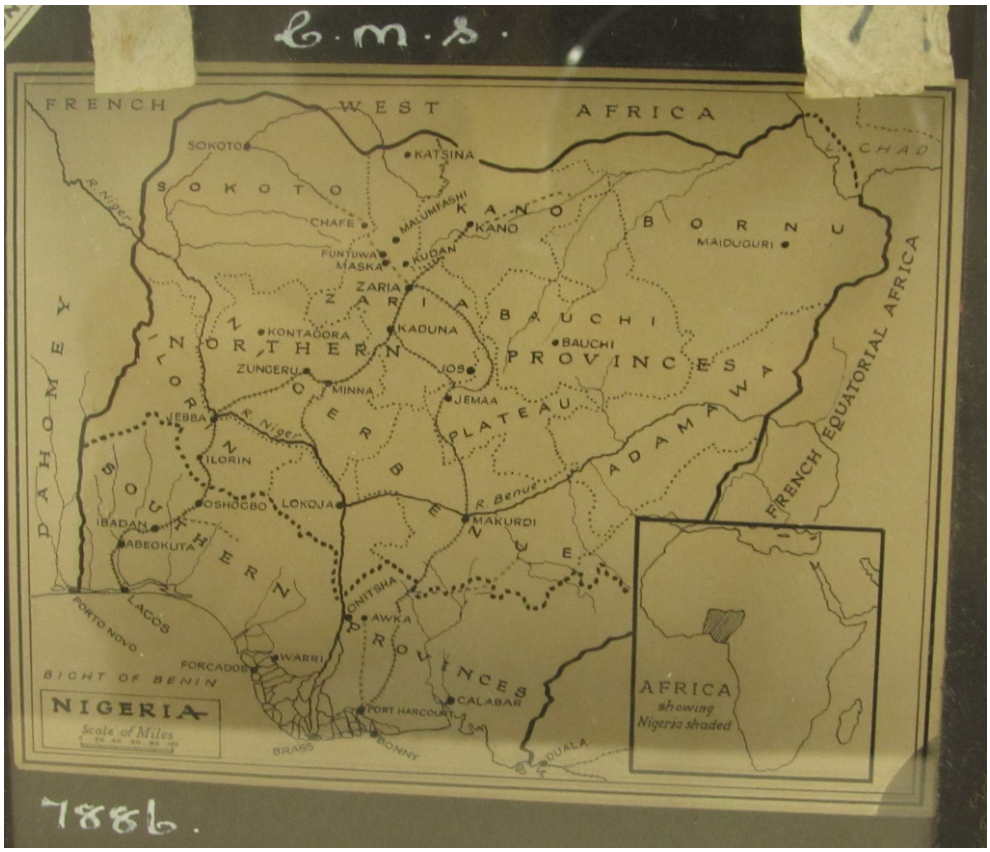

Figure 5: Map of Nigeria showing the two regions 1914, Source: Cadbury Research Library (CRL) ACC 444/Z1/1[23]

---

[23] Northern and Southern Nigeria were also referred to as Northern Provinces and Southern Provinces, respectively. These terms are used interchangeably in my dissertation. The North and the South were further divided into administrative provinces. In 1939, Southern Nigeria was sub-divided into Eastern and Western Region, each with

Colonial expansion in Africa did not often upset social and cultural practices except when these inhibited colonial governance. However, missionary involvement in the continent turned the colonial enterprise into a political and social force that altered indigenous customs and institutions. Missionaries sought the creation of a new social order that would uproot most traditional institutions, which they regarded as pagan.[24] There were attempts to reshape African culture to suit Europe's civilizing missions and portray African cultural practices as inferior.[25] Missionaries considered western education as the most effective means to evangelize and alienate younger generations

---

its provinces. Provinces in the Eastern Region included: Onitsha, Calabar, Cameroons, Owerri, Ogoja, Rivers. The Western Region provinces were: Abeokuta, Warri, Benin, Oyo, Ondo, and Ijebu. The Eastern and Western Regions are simultaneously referred to in colonial records as Eastern Provinces and Western Provinces. The regional provinces were split further into Divisions and Native Authorities, also known as Native Administrations.

24 E.A Ayandele, *The Missionary Impact on Modern Nigeria 1842-1914: A Political and Social Analysis* (London: Longman Group LTD, 1966), 3-5.

25 Jude Aguwa, "Mission, Colonialism, and the Supplanting of African Practices," in *Missions, States, and European Expansion in Africa*, edited by Chima J. Korieh and Raphael Chijioke Njoku (New York: Routledge, 2007), 128.

from their indigenous practices.[26] With time, women, considered as upholders of initiation rites and birthing rituals, became objects of missionaries' "civilizing" and evangelical efforts.[27] As Michael Jennings aptly states in his description of missionary tactic, "convert the mother, convert the child, and the entire community could thus be brought under Christianity."[28] The welfare of children and expectant mothers fell within this Christian goal.[29]

---

[26] Jehu J. Hanciles, "Bishop Crowther and Archdeacon Crowther: Inter-Generational Challenge and Opportunity in Africa Christian Encounter," in *Religion, History, and Politics in Nigeria* edited by Chima J. Korieh and Ugo Nwokeji (New York: University Press of America, 2005), 58; J.P. Jordan, *Bishop Shanahan of Southern Nigeria* (Dublin: Reynolds, 1918), 33-34; Aguwa, "Mission, Colonialism, and the Supplanting of African Practice," 141.

[27] Megan Vaughan, *Curing the Ills: Colonial Power and African Illness* (Polity Press, 1991), 23.

[28] Michael Jennings, "'A Matter of Vital Importance': The place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39'" in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, edited by David Hardiman (New York: Editions Rodopi B.V., 2006), 229. See also 247.

[29] Ibid., 229.

Through the provision of medical care, missionaries reached mothers and baptized infants in a scramble to gain as much converts for various Christian denominations.[30] In Nigeria, London's Church Missionary Society (CMS) and the Roman Catholic Mission (R.C.M), the largest missions in the colony, engaged in a race for infant baptism during medical care in the hopes that such baptized individuals would add to the number of their adherents.[31] Regions that embraced mission education accepted biomedicine more readily than areas where missionary education was not the main instrument of conversion and where competing religions like Islam had a strong presence.[32] The establishment of hospitals by missionary groups offered them greater influence among the local

---

30 See Vaughan, *Curing the Ills*, 22-23; Michael Jennings, "'A Matter of Vital Importance',"227. Jennings states that medical missions have been marginalized in the historiography of the construction of western medicine in British Africa, in which they played immense roles.

31 F.K. Ekechi, *Missionary Enterprise and Rivalry in Igboland 1857-1914* (London: Frank Cass, 1971), 75-78.

32 Ayandele, *The Missionary Impact*, 343-344 demonstrates how this feature played out among the Igbo and Yoruba ethnic groups of Northern Nigeria where missionary education was the strongest instrument of conversion. No other external religion competed with Christian influence among the Igbo unlike Yoruba land where Islam preceded Christianity and was a strong influence.

population, though the people remained suspicious of European medicine for much of the early colonial era. Biomedical centers in Nigeria did not thrive until after 1914.[33] In his description of missionary influences on modern Nigeria, Ayandele writes:

> Christian missionaries, fired by a faith to which they ascribed, rightly or wrongly, the enlightenment, progress, and technological interventions of their countries, perceived no wisdom in compromising with indigenous customs and institutions…. They sought the creation of a new social order which would wipe away most of the customs and institutions of the old society.[34]

He also states that "missionary propaganda was one of the potent factors in the expansion of British influence in many parts of Africa and many missionaries and administrators

---

33 Ibid., 343.

34 Ibid., 4.

recognized this fact."[35] Thus, though missionaries and the colonial government carried out somewhat differing policies, they often reinforced each other's objectives.[36]

In the effort to push their Christianizing mission, missionaries turned their attention to local birthing practices. In 1911, a missionary doctor stated that, "the 'unparalleled opportunity' of childbirth, of approaching a woman in 'her hours of greatest need,' offered 'greatest spiritual accessibility and receptivity.'"[37] Another missionary asserted in 1940 that, "no service rendered by a mission to a community is more appreciated and brings more vital contact with the people than does midwifery."[38] Christian missionaries upheld the view that social regeneration depended on women's roles, and that women were the embodiment of a moral Christian order and civilization.[39]

The line between colonial officers, missionaries, and medical staff in the early colonial era was blurred. British medical personnel were primarily colonial agents, and

---

35 Ibid., 30.

36 See Chima Korieh, "Conflict and Compromise: Christian Missions and New Formations in Colonial Nigeria," in *Missions, States, and European Expansion in Africa*, 147-148.

37 Hunt, *A Colonial Lexicon of Birth*, 201.

38 Ibid.

39 Nakanyike Musisi, "The Politics of Perception or Perception as Politics," in *Women in African Colonial Histories*, 99.

like their missionary counterparts, aimed at converting local communities to western culture and laying the groundwork for colonial expansion.[40] During the period after World War II, colonial governments collaborated with missionary groups in building and managing maternities. Before this era, colonial governments tolerated indigenous medical systems in areas where they were the only available source of healthcare for African peoples.[41] Charles Good, suggests, for instance, that the British colonial government in Kenya intentionally encouraged reliance on indigenous healers and midwives by minimizing resources allocated to health.[42] Only a few scattered mission hospitals provided any sort of biomedical care for the African population until the First World War.[43] Medical departments catered almost exclusively to the small European settlers, with secondary concern for the Asian and African labor force that resided in the urban centers and on whom the European population most relied. In South Africa from the 1860s, white legislatures criminalized all types of African practitioners but chose to

---

40 Aguwa, "Mission, Colonialism, and the Supplanting of African Practice,"138.

41 Ibid., 141.

42 Charles Good, *Ethnomedical System in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya* (New York: The Guilford Press, 1987), 90. He states that this position is arguable.

43 Ibid., 83.

license midwives and herbalists (Inyangas) in 1891.[44] Nancy Hunt observes that Africans in Belgian Congo plantations relied on traditional midwives for childbirth. However, birth was rewarded by plantation owners through bonus pays, inscription of the baby's name on the plantation books for children, and a gift of cotton cloth for the mother.[45] It was not until the interwar period that maternal and infant health as a movement to save the lives of mothers and children emerged on a global scale, launching the construction of maternities in this and other regions.[46] In Egypt, on the other hand, midwives known as *Dayas* were increasingly discredited by British colonial authority from the late nineteenth century.[47] This was a product of the exclusionist medical professionalization that occurred in the Egyptian as well as other African settings. In some colonies, traditional midwifery remained uninterrupted until the World Wars. It was Christian missionaries who provided much of the maternity services before this post-war period.[48]

---

44 Flint, *Healing Traditions*, 2.

45 Hunt, *A Colonial Lexicon of Birth Ritual*, 237-238.

46 Ibid., 239.

47 Hibba Abugideiri, *Gender and the Making of Modern medicine in Colonial Egypt* (Burlington: Ashgate Publishing Company, 2010), 115.

48 See Ibid. Gelfand states that African women were not yet ready, during the early colonial periods, to entrust themselves to western midwives or hospitals for births but preferred to trust their traditional midwives, known as *ambuya* or *nyamukuta*.

Efforts to westernize childbirth were not entirely successful because traditional birth rituals and practices reflected the peoples' social structure.[49] What emerged were hybrid practices that were a result of subtle negotiations and refashioning. Local cultural practices were infused into the fabric of the new medicalized and western birthing culture. The result was a set of practices suitable to the changing socio-cultural atmosphere. In an African setting, after all, childbirth echoed a complex set of goals, virtues, agendas, cosmological concerns, and social support systems. Notwithstanding, involvement in childbirth offered missionaries new forms of social power. Hunt makes a conclusive statement about missionary interest in obstetrics by stating that, "lowering maternal mortality was never the express purpose of colonial midwifery…. Evangelization, 'getting the girls,' and producing a 'trained staff of female nurses' were the missionaries' goals."[50] In such a climate, traditional midwives refashioned for themselves new goals and identities.

Methodology

Contested Spaces is based on qualitative research and utilizes oral traditions, semi-structured interviews, archival documents, and museum artifacts to reconstruct and

---

49 John Janzen, *The Social Fabric of Health: An Introduction to Medical Anthropology* (New York: McGraw-Hill Publishers, 2001), 8.

50 Hunt, *A Colonial Lexicon of Birth Ritual,* 204.

analyze birthing practices during the colonial era. My methodological approach incorporates a close analysis of primary documents and the historical contextualization of these records within a broader socio-cultural framework.

This research began with a preliminary trip to Nigeria in the summer of 2013. I visited the Nigerian National Archives Enugu, and the Department of History Library, University of Nigeria, Nsukka (UNN). During this trip, the foundation for this project was laid. Some of the documents secured at the National Archives, Enugu, treated "native" medicine, in general. They also included anthropological reports on various groups from the Southern Provinces of Nigeria. There were records of midwifery training as well as other medical developments in Nigeria. One thing that was evident from this archival visit was the lack of narratives about traditional birthing practices. Apart from C.K. Meek's anthropological report on Igbo customs, which included information on birth rituals sparsely distributed across its pages, data on childbirth among Nigerian cultures existed in scanty forms, often submerged under brief sections on marriage. It is here that the History Department Library at the University of Nigeria (UNN) offered some respite.

As part of its Bachelor's degree requirement, UNN's history department required students to write "B.A. projects" in which they included unabridged and unedited oral interviews used in their work. These projects became a good resource for acquiring earlier interviews on birthing customs as well as obtaining directions for my oral history

projects.[51] In addition to the interviews obtained from this research, I conducted several preliminary interviews in Nsukka, Enugu, and Adazi-Enu, three communities in southeastern Nigeria. These interviews were mostly regarding traditional midwifery. Interests in Safe Motherhood programs and their relationship with traditional midwives also took me to rural health centers and the Ministry of health in Enugu State. The information obtained here included materials for the training of traditional midwives, and a list of midwives whom I could interview. This list was limited to traditional midwives who had received training in Safe Motherhood programs. It also provided names and villages but barely any contact information. Therefore, I found myself making trips to rural communities with no guarantee that I could meet with the midwives whom I sought.

The trips also took me to communities where I had to walk many miles with no hope for transportation back to the township. After the first few trekking experiences, I recruited drivers who had to stay with me throughout the duration of my interviews. These companions proved very useful as they often inserted themselves into the interview with their own questions or further clarifications. My transport experience made me

---

51 The most relevant of these works include: Eze, Judith, *Traditional Birth Control in Iheaka, Igbo-Eze South LGA*, B.A Thesis, Department of History, University of Nigeria, Nsukka, 2008; Chioma Akawuba, *Traditional Midwifery and Child Care in Ebenator Ekwe Isu LGA Imo State, 1900-2005,* B.A. Thesis, Department of History, University of Nigeria, Nsukka, 2011.

appreciate the importance of resident traditional midwives in these areas during this contemporary era. There were no easy ways to access a hospital in case of unplanned labor or other emergencies. I could see the ruins of health centers from the colonial era. These centers operated in lieu of hospitals in these communities.

The summer of 2015 to 2016 was a significant period in the development of this project. All archival and oral records were collected during this time. The archival research occurred in Nigeria and the United Kingdom. In Nigeria, it included two archives– the national archives in Enugu and Ibadan. The archives in Enugu held information mostly on medical developments in Igboland while the archives in Ibadan produced a more specific kind of document. It had four detailed files on the *Aladura* Movement in Nigeria, including information on its origins and colonial responses to it. However, it yielded no information on the existence or operations of birthing homes. This is an aspect of the movement that had to be uncovered mostly through oral interviews. I also gathered documents on the development of hospital birth in Western Nigeria.

My research in the UK involved five archives: Cadbury Research Library, Birmingham; Royal Commonwealth Society Library, Cambridge; British Library, London; Wellcome Library, London; and British National Archives, Kew. The library in Birmingham housed all Church Missionary Society's documents and provided in depth insight into missionary activities in Nigeria as well as maternity works. It had extensive records of one of the society's earliest medical missions at the CMS Mission Hospital (later Iyi-Enu Hospital). The archive also had documents on the activities of African

Independent Churches, including glimpses into prayer books and church constitutions. These documents informed my knowledge of the attention given to matters of childbirth as well as the infiltration of local belief systems into the new churches. By providing the missionary's and the local Aladura's perspective rather than that of the colonial administrator, the records y complemented similar materials obtained from Nigeria's archives in Ibadan. Some CMS periodicals, notably The Church Missionary Gleaner and the Medical Missionary, were useful for discourses on the origins of medical missions and the mindset behind missionary involvement in maternity services.

Materials from the Wellcome Library and British Library proved very important for this research in a strategic way. At the time of this research, trips to Northern Nigeria was prohibited by the University of Texas at Austin, who provided funding for my research trip. This had the potential of limiting my scope to Southern Nigeria since I could not visit the national archives in Kaduna. Missionary reports for the North up to 1908 were classified under the Niger Mission, so acquiring information for missionary activities in the north during this period was not entirely a problem. The later periods were, however, problematic. Fortunately, the Wellcome Library collections included all medical reports for the Northern Provinces from 1905 up to 1959. Besides information on Northern Nigeria, the Wellcome Library provided detailed medical reports on all the provinces of Nigeria as well as information on the birth control politics in which an independent Nigeria was immersed. These included pamphlets and posters on safe motherhood projects. The documents on birth control are utilized mostly in the epilogue.

The British Library provided more materials on the north. Through the "endangered archives" program, the library was in the process of digitizing all pre-1924 documents from the National Archives, Kaduna, Nigeria. The documents were, therefore, accessible to me digitally for the duration of my research at the library.

Images and visuals are important to every story. This is where the Royal Commonwealth Society Library at Cambridge and the National Museum, Enugu, Nigeria come in. The library had pictures of colonial Nigeria from the nineteenth century. Some of the collections contained pictures and notes on midwifery and health propaganda, such as puppet shows and baby shows. These pictures augment the written texts from other archives. National Museum, Enugu held collects of ritual items, especially those associated with fertility, childbirth, and infant mortality. These items, as well as the notes appended to them, yielded useful information about traditional birthing practices.

The British National Archives, Kew had the most extensive collections on colonial Nigeria. Official correspondences between colonial administrators in Nigeria and officers in the metropole, including general resolutions and reports, are housed in Kew. The files that I acquired included annual medical reports, foreign and colonial office files, records on medical developments in Nigeria, and reports on the colony's various colonial districts. Anthropological reports were also useful for evaluating the place of women within the imperial system.

Rockefeller Archive Center, New York is one archive whose documents are barely incorporated throughout the dissertation. This archive yielded documents on the

evolution of birth control politics in Nigeria from 1960 as well as the various interventions by US foundations to enhance reproductive health. The initial plan for this study included the transition from interests in maternal mortality to birth control shortly after Nigeria's independence. This aspect of my study was shelved at this stage because of the desire to limit the scope to the colonial period (1900-1960). I refer to the Rockefeller collections in the epilogue. However, documents from this archive will feature prominently in a revised version of this work, which will have an extended scope.

Oral interviews play an important role in this study. They provide data on traditional birthing practices and taboos as well as information on faith delivery homes, largely absent in written sources. Chapter two and part of chapter three, for instance, derive mostly from oral interviews and a collection of oral traditions. My interviews totaled fifty and spanned across six states in Nigeria: Osun, Enugu, Imo, Anambra, Oyo, and Lagos. My interviewees include traditional and faith-based midwives as well as elderly individuals who have accounts of these birthing and reproductive practices. I also interviewed a few medical staff who worked in the colonial medical service, women who utilized traditional midwives and faith delivery homes during childbirth or who have memories of these practices from the colonial era, and AIC church leaders. Through their accounts, I retrace traditional and faith-based midwifery during the colonial era as well as the nature of the interactions between these practices.

On Names and Labelling

What's in a name? Who does the naming? Naming is an important component of every civilization. In many settings, it determines the positionality of that being named. It has also been a weapon of colonial domination used by imperial forces to shape narratives in specific ways. In writing about childbirth in Nigeria, I am conscious of labels and names, and the purposes which they serve. This concept applies to the ways that terms associated with traditional midwives in the developing world have been created. For instance, traditional doctors are designated as herbalists or healers, and in this way placed in subordination to their biomedical counterparts. Early in the twentieth century, they were even referred to as witch doctors. Through language choice, medical practices emanating from developing countries have, thus, been put in a subservient position and recognized not as medicine but as an "other". Consider the case of a newly converted *dibia* (local doctor) who approached some colonial officers in Nigeria during the 1920s with a proposal to institute a school of medicine where traditional medical practices would be taught, devoid of the African religious system.[52] His proposal was aimed at preserving the medical knowledge emanating from the community. He was rebuffed, and his practice (and that of other traditional doctors and medical practitioners) was deemed as quackery because it did not fit into a western paradigm of science and

---

52 See Elizabeth Isichie, *A History of the Igbo People* (London: Macmillan Press LTD, 1976), 223.

medicine or medical education. Such is the condition of African medical systems and the power that labels wield over them as an "other" and lesser therapeutic form.

In *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa,* Karen Flint poses the question, "what is 'traditional' about traditional healers and medicines?" This question caught my attention earlier on in my research and influenced the ways that I treat labels. "Tradition" has been appended on African descriptions to depict age-old practices that are tied to specific cultures. This research portrays "tradition" not as fixed but as a porous construction that is constantly being negotiated as new cultural and geographic encounters occur. Midwifery in this study is, therefore, not explained as static but as a dynamic set of practices that have shifted over time in response to internal and external forces, such as urbanization, migration, religion, and geography. This work employs the term "traditional" to distinguish between the local and colonial/biomedical. Where "traditional or local medicine" is used in this text, this does not designate any rigid forms but merely a distinction between what is domestic and what is foreign. Though it has maintained certain core values over time, traditional African medicine reflects external influences of economic, political, and religious nature. As Flint makes clear, the utility of "tradition" lies in its flexibility and the ways that it can be used to support or condemn practices.

A more problematic categorization which this work desists from applying is the term, Traditional Birth Attendant (TBA), common in studies of midwifery in Africa. The definition of the term depends on who you ask. TBAs have been understood simply as

traditional midwives. In other settings, they have been described as traditional midwives with some government training. Here again lies the problem of labels and the power-position of the labeler. TBA was a category introduced by the World Health Organization in the 1980s to classify people (midwives) who assist women during childbirth. The term is problematic because it privileges one cultural system over another. While the name applies to midwives in developing countries, it is not generally applicable to midwives in the developed world. Those in the latter category are described simply as midwives.

The term, TBA, when reserved for practitioners in the developing world, denotes the lack of any systematic medical training. In this way, indigenous knowledge systems are written off as non-scientific and inferior to western educational systems. This categorization, therefore, stripes the categorized of any power and agency within biomedical discourses. As this research establishes, training within the indigenous educational system existed for midwives. *Contested Spaces* deliberately represents traditional midwives as midwives, using the word "traditional" to set them apart from their biomedical counterparts. Contrary to usual belief that the traditional midwife offered no medical and therapeutic care to pregnant women during pregnancy but simply attended the birth to "catch the baby," this research captures the essence of medical care as embodied by the midwife. Chapter two, for instance, discusses the nature of medical and emotive care provided by the midwife. Where applicable, traditional midwifery is described with its local terminology, such as *Oji Nwa* or *Iya Agbebi*. The act of midwifery is described in chapter two as *iji nwa* (midwifery).

Chapter Two

"The Past is still with Us": Reflections on Traditional Midwifery and Birthing Practices Among the Igbo prior to 1960

Introduction

"The past is still with us," stated an Nsukka midwife. "You ask me about childbirth in the olden days as though these things no longer exist." If you go to the interiors of my natal home, Ibagwa, you will see the practices described as 'olden days' still in play," she finished.[53] This statement was the beginning of an interview with Chizoba who has been a midwife since the 1950s and whose mother and grandmother were also midwives. Her practice was passed on to her from her mother. Chizoba's comments highlight the importance of cultural survival and adaptations in Nigeria's birthing traditions. She found it ludicrous that the practices which represented the reality of women in her largely rural community was referred to as "past." Her statement referred to the social contexts of birth and the cultural enactments that symbolized them.

---

53 Chizoba, c.78, Interview, New Anglican Road, Oba, Road, Nsukka, April 9, 2016.

Childbirth is a natural process, but it is constructed around cultural values and norms.[54] According to Martha Loustaunau and Elisa Sobo, every society has its "organized patterns of relationships between individuals and groups within a society, which orders their behavior in a predictable fashion and influences their interactions."[55] This applies to childbirth, whose rituals and interactions must be placed within a cultural context.

Conceptualizing Igbo Motherhood

Motherhood among the Igbo transcends a biological concept and represents a social institution. Along with other social establishments in Nigeria, it is far from static and has been redefined to suit historical moments such as colonialism and the post-colonial era. However, one thing stayed constant: it has remained a notion that untangles the social, cultural, spiritual, and biological aspects of maternity. Unpacking Igbo motherhood offers insight into the importance of missionary decision to target birthing institutions as a strategy for advancing Christianity.

---

[54] John Janzen, *The Social Fabric of Health*, 8

[55] Martha Loustaunau and Elisa Sobo, *The Cultural Context of Health, Illness, and Medicine* (Westport: Bergin and Garvey, 1997), 22.

Motherhood bestowed on married Igbo women power and social status. It solidified a woman's position in her marital home and the society. It also solidified the bonds between the two families involved in a marriage contract. Established rituals often marked these relationships. Upon becoming a mother, an Igbo woman secured her own *mkpuke* (house) over which she wielded control. Her *mkpuke* was also the point of congregation and socialization for her children. This space was outside the control of husbands, and it was the maternal ideology that bound relationships among *umunne* (children of the same mother) and framed a family's genealogy. In this way, motherhood conferred on a woman the advancement into full adulthood but also gave her autonomy within her marital household. A mother could participate fully in various political associations and could express her opinions where an unmarried or barren women could not. Since the family was also the center of labor supply in subsistence and agricultural economies, the size of a woman's household determined the extent of labor from which she or her husband could draw. This is especially important because married Igbo women received plots of land from their husbands from which they grew produce for sale and consumption. This correlation between family size and labor also made the overall dimensions of a man's household important.

Mothers also wielded spiritual powers and were in control of rites associated with *omumu* (fertility). Deities associated with productivity, for instance *Ala* (earth goddess), were portrayed as mothers, reflecting this female power. This spiritual power is reflected in the reverence for *Inyom-di* (patrilineage wives) and *Umuada* (lineage daughters), who

control specific religious rituals in their lineages and wielded political and judicial power over men in certain circumstances. It is also in regards to the spiritual bearing of motherhood or a woman's status as *nne* (mother) that her nude body becomes a spiritual object that is revered and could be coopted by women for protest. *Nne* is no longer just a daughter but a woman imbued with ritual authorities with which she could influence her community. For instance, mothers dominated public ritual ceremonies and rites associated with deities related to specific crop production. They also controlled rites associated with fertility. Most importantly, especially for missionaries, mothers exerted ideological influences within their homestead and communities.

Nwa Agadi: Marriage and Conception

Nwa Agadi, which translates to "old person," is an affectionate term used by Igbo people to address a pregnant woman. Women desired this salutation upon marriage. Therefore, efforts were made by adolescent girls, their mothers, and their in-laws to ensure a woman's fertility. The attainment of this goal started before formal marriage contracts were established. Various rituals were enacted to ensure fecundity. The Igbo religious cosmology vested in women, female ancestors, and female deities the powers of procreation. Mothers and grandmothers offered sacrifices to ensure the fertility of their daughters. Women's ability to harness the spiritual forces of procreation lay in their activation of *omumu* through sacrifices to their natal maternal spirits. Women also made sacrifices to their *chi* (personal spiritual guardian) to clear any spiritual obstructions to

conception. In matters of fertility, a woman's *chi* was not considered very effective in maternal issues until the birth of a woman's first child. Therefore, her mother's *chi* or that of other maternal ancestors were invoked to protect her during a first pregnancy.

Fertility dances were performed at the end of marriage ceremonies by the bride's *umuada ndikiride* (married female members of a woman's kindred). In some communities where *iyi*, an oath that dissuaded men from lying with an unmarried woman, was placed on a woman, the *iyi* was taken away by the *umuada* relatives of the bride, allowing her to engage in intercourse, with the aim of conception. Married women who were unable to conceive after years of marriage could return to their parents for a period of spiritual and physical treatment.

Pregnancy was punctuated by ceremonies performed to ensure safe maternity. These observances highlight the Igbo's cultural affinities. The communities of the expectant couple were intimately involved in this process. The expectant husband visited his wife's village, bearing a cock as gift for the priestess or priest of *Ala*, the earth goddess and most powerful deity associated with fertility. The priest or priestess of *Ala*, in turn, invoked divine protection for the pregnant woman, notifying the goddess that the woman's husband fulfilled all marriage rites for their daughter. Afterwards, the husband proceeded to the wife's family to officially notify them of her conception.[56]

---

56 C. K. Meek, *Law and Authority in a Nigerian Tribe* (London: Oxford University Press, 1937), 285, 287.

At the fifth month of pregnancy, the couple made a formal visit to the woman's family with palm wine and gifts for the mother-in-law. This visit lasted for a few days, after which the expecting mother received valuable gifts such as goats, fowls, water pots, and mortars from male members of her extended family. These gifts were practical items that every married woman needed to build her expanding home. On return to her marital home, the expectant mother offered gifts, usually pieces of coconut and meat, to children in her husband's extended family. These were the future companions of her unborn child. [57] She also shared other edible items that she received with members of her husband's family, especially the man's parents, as these were expected to reciprocate with gifts to their in-laws following the child's birth.[58] These exchanges marked the peoples' intricate networks and support systems, and cemented social bonds. Childrearing was a communal affair rather than the sole responsibility of parents. Close affinities were, therefore, established between babies and their maternal families to secure lifelong support systems for them.

The Igbo have a common belief that the attributes of animals could influence the traits of a fetus. Therefore, pregnant women were proscribed from eating certain foods especially in the first four months of pregnancy. They avoided the flesh of slow-moving animals such as *nchi* (Grass Cutter) as this may impede the baby's ability to walk; snails,

---

[57] Ibid.

[58] Ibid., 288.

because they oozed saliva and could make infants becomes imbeciles; pig meat which was believed to induce abortion; or the flesh of any animal that died on its own as this may cause still birth.[59] Banana was believed to make the child weak, and was therefore avoided. Plantain, pumpkin and walnut were avoided during the first four months of pregnancy. Additionally, pregnant women were advised against beholding ugly things because the fetus could resemble such things.[60] These rules varied from one part of Igboland to the other. Pregnant women were barred from visiting a household in the event of another expecting mother's death. Also, they could not carry a newborn. A violation of these rules could cause bleeding or induce abortion. The fetus could perceive the presence of an infant and may become unduly restless, as a result.[61]

Some of the taboos extended to husbands. In some communities, expectant parents were barred from eating the meat of animals killed in honor of a deity and sold in the market. One wonders how such couple would determine such sacrificial meat. If this rule was broken, a miscarriage could occur or an abnormal child could be born.[62] In other areas, husbands were prohibited from killing snakes because they embodied some aspect

---

59 Ibid. 269

60 George Basden, *Niger Ibos*, London: Franc Cass, 1966, 169-176; Meek, Law and Order, 289.

61 Chizoba, Interview cited.

62 Meek, *Law and Authority*, 289.

of the human soul. Likewise, husbands could not refuse food cooked by their wives, otherwise, the new born would refuse food and die. They were to avoid carrying dead bodies, even those of animals, lest their babies should die in the womb. These taboos were not absolute laws, but their breach could entail condemnation of the defaulting party if things subsequently went wrong.[63]

Some taboos imposed on men during their wives' pregnancy ensured the control of physical and verbal abuse from husbands. Communities in Imo State performed a festival, *Ajankita*, at the end of which the couple promised to be pleasant and "sweet mouthed" to each other. The rule that compelled men not to refuse food offered by their wives to avoid a stillbirth also served the purpose of checking mistreatment. It offered emotional protection even for a disfavored wife. As children were a source of prestige and status for Igbo men, they were mostly bound to comply with the proscriptions placed on them.

Iji-Nwa: Birth and the Midwife

Like other aspects of indigenous medicine, the birthing process was based on roots, herbs, rituals, and cultural philosophies. Traditional midwifery up to the mid twentieth century was a gendered profession. Midwives were almost exclusively women,

---

63 Ibid.

and men were isolated from affairs of child birth.[64] Husbands were instead occupied with making appeals to their *Chi* through sacrifices and prayers to grant their wives safe delivery.[65] Afterwards, the male members of the extended family waited in anticipation until the infants were born. The exclusion of men was more common in eastern and western Igboland. Here, women who discussed matters concerning childbirth with men received backlash from their peers. In northeastern Igboland, on the other hand, older male family members, including a woman's husband, could assist during childbirth. There were accounts of men whose wives sat on their laps to deliver their babies. In this case, they served as human stools and a restraint for the expectant mother.[66]

The exclusion of men from the birthing space in many Igbo communities was perhaps women's way of appropriating an intimately feminine domain of control and collective solidarity. It is also possible that men made a virtue of childbirth to exclude themselves from it.[67] Then, there is the matter of modesty and male gaze on the female body. From an Igbo girl's childhood till marriage, *oto* (the state of undress) was a sign of health and public beauty. With the conception of a first child, however, her nude body

---

64 C.K. Meek, *Law and Authority,*52, 101.

65 Ibid. 58.

66 Ogidija Ugwuole, c.95, Interview at Amaube Village, Lejja, Nsukka, April 5, 2016; Onyeugwu Ogwo, c.102, Interview at Umuodaeze Village, Lejja, April 6, 2016.

67 Chalmers, *African birth*, 44.

becomes sacred, to be revealed only to her husband within a private space.[68] Thus, it is possible that the issue of men other than a woman's husband participating in the intimate procedure of delivery may have curtailed men's involvement in birthing. This concern trailed the encroachment of men into the field of midwifery across the world. However, while the gaze on the female body explains men's exclusion from midwifery, it does not clarify the husband's exclusion. In communities where the husband was excluded, he was only allowed into the scene after the child had uttered its first cry and he was officially informed by female family members or the midwife that his spouse had put to bed.

Nevertheless, in cases of serious complications, a male or female *dibia* (traditional medical doctor) who possessed medical and spiritual powers was invited to aid delivery. Evidence of this collaboration was depicted in an early twentieth century artistic illustration of childbirth, found behind the shrine of a deity, *Olugba*, in the Igbo town of Owerri. The sculpture depicts a female attendant standing behind a woman giving birth and, holding her shoulders. In front of the woman was the midwife positioned to receive the baby. At the side stood a *dibia* holding a bunch of leaves or

---

68 See Misty Bastian, "The Naked and the Nude: Historically Multiple Meanings of Oto (Undress) in Southeastern Nigeria," in *Dirt, Undress, and Difference: Critical Perspectives on the Body's Surface,* edited by Adeline Masquelier (Bloomington: Indiana University Press, 2005)

other charm to facilitate delivery.[69] It is possible that male herbalists and diviners who also doubled as midwives always existed in northern Igboland, among the Nsukka, Udi, and Abakiliki Igbo.[70] These herbalists were famous for their treatments of infertility and other gynecological ailments like fibroid.

Figure 6: Birthing Posture. Source:

http://wellroundedmama.blogspot.com/2015/03/historical-and-traditional-birthing.html

---

[69] Ibid. 51

[70] Some of the midwives interviewed in different towns in this area in 2011 were men. Their date of birth fell between 1910 and 1925. Other old female midwives in these areas also recalled male midwives. These men were also notable healers and diviners. In the same Northern Igbo area in contemporary times, it is not unusual to see a male midwife who is almost always an herbalist.

No formal training existed for the midwife; however, those interested in the profession became attached to experienced midwives. They ran errands for the senior midwife and provided comfort and emotional support for pregnant women during labor. For children of midwives who developed interest in their mothers' work or were taken along to birthing sessions, their authenticity was easier to establish. They acted as junior midwives. In addition to assisting their mothers during these sessions, they were assigned the care of sick pregnant women. From here, the community's trust in the apprentices' abilities developed until they could take on more demanding responsibilities. The legitimacy of midwives depended on the success of their practice and the community's confidence in their skills. Though young women received training as midwives, they could not practice independently until they were married and had children of their own. This was because of the reasoning that midwives would provide better maternal and child care if they had children. Midwifery was, thus, closed to unmarried or barren women.

Traditional midwives were central actors in the early stages of pregnancy. As soon as conception was discovered, the midwife's service was engaged. In some communities, a diviner was consulted to select the appropriate midwife that would carry out a successful delivery.[71] Afterwards, the midwife examined the pregnant woman's

---

71 Makata Eze, Interview, March 28, 2008.

condition and that of the fetus. She was then given herbal mixtures that she must take judiciously at scheduled times.

Midwives believed that any abnormal increase in body temperature during the early stage of pregnancy could induce abortion; therefore, they advised women against taking hot showers at this stage, and fever was promptly treated. They also massaged the back and abdomen of pregnant women to increase blood flow. This procedure was also an opportunity to bond with the expectant mother. As pregnancy advanced, the fetal position was checked, and if necessary, the fetus was repositioned. Skilled midwives prided themselves in their ability to maneuver the baby from the breech posture to an appropriate position.[72] They obtained a clay pot, added palm oil, and heated the oil on an open fire. Afterwards, *Akpaigogo* (a part of the palm fruit) was added and the mixture stirred into a paste. This paste was rubbed on the woman's abdomen while the midwife gently manipulated the baby. With the help of the mixture and the midwife's technique, the baby turned into the proper position and labor progressed normally.[73] Unskilled or inexperienced midwives did not attempt this feat as it could lead to complications or rupture the uterus.

Midwives instructed pregnant women on appropriate nutrition. Fatty foods that would enlarge the fetus and therefore make delivery difficult were generally avoided.

---

[72] Mary Ugwuanyi, c.89, Obollo Road, Nsukka, June 26, 2013.

[73] Ugwuole, Interview cited.

These included fatty meat and pounded yam, the latter being a prominent carbohydrate-rich staple of the Igbo. She was instead encouraged to eat more fruits, vegetables, and the appropriate amount of protein-rich food.[74] She also consumed herbal soups.

The beginning of the first genuine contraction was a crucial period. Once the earliest signs of labor manifested, the midwife was immediately summoned. Culturally, childbirth occurred in the expectant mothers' backyard or that of her father or grandmother. In some communities, however, childbirth could occur in the midwife's backyard because the midwife had everything she needed for the birthing process handy.[75] Giving birth inside houses was considered a taboo up to the late colonial era when Christianity and western attitudes had taken deep roots among the people. This practice has been ascribed to sanitary reasons. Birthing outside the house kept birth fluids from contaminating household items and food, and made it easier to clean up the birthing space. [76] Women's body fluids, notably blood, were considered a spiritual contaminant, neutralizer, and weapon that could be used to ensnare the new mother and her infant.

On the midwife's arrival, she encouraged the pregnant woman to stay mobile to speed up labor. She accompanied the woman throughout this process, offering verbal comfort and reassurance. The woman was considered ready for delivery once she felt the

---

74 Ibid.

75 Meek, *Law and Authority*, 290; Nnanna Okorom, Interview, March 2, 2011.

76 Chizoba, Interview cited.

urge to excrete or had a distended perineum.[77] Delivery postures differed from one Igbo community to the other, however, the squatting position in which the woman sat on a stool was more common. In this case, one or two female relatives or assistants stood or sat on a higher stool behind her, holding her across the chest while the expectant mother wrapped her arms around the assistant's neck. The restless woman's knees were held apart by other female attendants or the midwife who wedged her knee between that of the woman.[78] Another posture that was commonly assumed in Northern Igboland involved the installation of poles in the backyards. Women assumed an upright position and gripped the pole while the midwife was positioned to receive the baby. In any chosen posture, the baby was not allowed to touch the ground. This was a check on the midwife to ensure that the baby did not fall to the ground upon delivery and thereby come to harm. Though midwives had no scientific training, they adopted birthing postures that harnessed the power of gravity to enhance the baby's expulsion.

The arrival of a new born was not announced until the placenta had been expelled and the baby had cried.[79] The umbilical cord was cut with a sharp traditional blade usually obtained from the raffia palm. The midwife held the cord between her fingers,

---

77 Ugwuanyi, Interview cited.

78 See Meek, Law and Authority, 290; V.E. Egwuatu, "Childrearing among the Igbos of Nigeria," *International Journal of Gynaecology and Obstetrics*, 24: 1986, 106.

79 Odo, interview cited; Felicia Agu, Interview, March 5, 2011; Basden, *Niger Ibos.*

pretended to cut close to the base, and asked other women present at the birth if she should cut at that point, they yelled 'no," in unison. This act was repeated until she reached the appropriate part of the cord for cutting. This point is marked by a natural margin or ridge, which the midwife recognizes by feeling the cord. Afterwards, the baby was cleaned with warm water and laid on a bed made of fresh piles of *obobochi* and cassava leaves. [80] Plantain leaves were added to the base of the bed in some locations. The mother's abdomen and pelvic region was massaged with hot water. This was aimed at stopping blood-clotting in the womb and causing easy outflow of body-fluid collected in the uterus. In many areas, a local bed made of molded clay and wood was kept heated. Pounded piles of *igbegiri* (a part of the palm tree) were placed at a spot on the bed to absorb the bleeding from the mother's uterus. The baby was given a small amount of palm kernel oil and little water, and then covered in *odo*, a local powder. Visitors and relatives applied same powder on their face and neck, and this sight in any neighborhood signified the arrival of a new born. The umbilical cord attached to the placenta, was then buried and a tree planted on that location to mark the birth of the child. In some locations, such as Ututu and Arochukwu, the cord was put into a ritual pot made of clay, copper, or iron – Ite ola okike (pot of creation).[81]

---

80 Ogwo, Interview cited.

81 "Ite Ola Okike," National Museum, Enugu Nigeria.

Before breastfeeding, the mother's milk was tested to ensure that it was safe for the baby. The milk could not be given the baby until it was certified by the midwife or other older women to be harmless.[82] A small quantity of the breast milk was spilled on cocoyam leaves; if the leaf turned brown or showed signs of withering, the milk was declared unfit for consumption. Another alternative was to spill the milk on the floor; if ants failed to lick it, or they did and died, then the milk was identified as poisonous. To induce a reasonable flow of breast milk, the breast was massaged with oil from palm nut. Chewed palm kernel was also rubbed on the nipples to make it firm.[83]

At the end of childbirth, midwives' services were rewarded in kind. In some communities in Northern Igboland, the midwife was considered as "blinded" by the birthing process. In order to open her eyes, the family of the new mother offered different gifts and food stuff.[84] Among other communities, she was given a fee of one rod (a traditional form of currency), yams, and firewood. In places like Mboo in Imo state, if the child was male, the midwife was presented with a cock a few days after childbirth. She pressed this cock on the mother and child saying, "I remove from you all evil spirits."[85]

---

82 Basden, *Niger Ibos*, 125.

83 Ibid., 111

84 Ewereji Rita, Interview, March 5, 2011.

85 Meek, *Law and Authority*, 292.

Then, she killed the cock at the threshold of the compound and took the meat home for her use.[86]

If a midwife lost mother and child during childbirth, she was obliged to mourn them. During the mourning period, she desisted from attending to any pregnant woman. She applied camwood and *Nzu*, a local chalk, on her palms and face, indicating her loss. As long as the chalk remained on her, no pregnant woman could engage her services. Such losses were a source of shame to midwives; therefore, they did their best to prevent the community's loss of confidence in their skills.[87] This use of color to depict the condition of the body as whole or unfit corresponds with medical anthropologist John Janzen's observation that several color codes were used across Africa to depict the body's nature. White chalk represented purity and wholeness while red or camwood depicted transition and danger, sometimes associated with bloodshed.[88] The combination of white and camwood by midwives in mourning signified that what was once whole had now become contaminated with bloodshed.

After birth, the care of mother and child shifted to the woman's mother, who taught her daughter proper childcare techniques and nursed her back to good health for a period of one to three months. This interval was known as *Omugwo,* a time when the new

---

86 Ibid.

87 Janet Nwosu, Interview, May 5, 2011.

88 Janzen, *The Social Fabric of Health*, 62.

mother got good rest from pregnancy and childbirth. It was customary for the baby's maternal grandmother to buy gifts of wrappers, dry meat and fish, and other food items with which she visited her daughter's home for *omugwo*. For average families, the new mother was fed whatever food was available. She was fed properly, nonetheless. In Northern Igboland, *ogbono* or okra soup was the favored meal for a new mother. Prominent families placed new mothers on a special diet of fresh pounded yam and *ogbono* soup. The food was finished after it was made, and a new batch of food was prepared for the woman whenever she demanded more food.[89]

In other parts of Igboland, the woman ate yams cooked in herbal sauce or pounded yam and *nsala* soup, a delicacy rich in proteins and herbs that aided healing. She was habitually given hot water to ease the womb. During this time, the new mother also squatted over bowls of hot water infused with some herbs. The steam from the water was expected to heal the womb as well as tears from birth. The new mother's lower abdomen was massaged to loosen up any "bad blood" retained in the womb. The *omugwo* period was, therefore, a time of healing and recuperation. Household chores were taken over by the grandmother and other female members of the extended family. At that time, extended families lived in close proximity.

In the Awgu division of Igboland, the midwife had one final role after delivery. One month after a child's birth, formal rites of purification were performed. The new

---

89 Ogwo, Interview cited; Ugwuole, Interview cited.

father invited the women of his kindred to a feast. The midwife attended and waved a yam over the head of the mother and child, saying, “May everything that comes into this compound be pleasant like this feast. The evil spirit shall not assail the mother and child, for I am now removing all evil spirits from this household.” She then threw the yam on the ground.[90] A young boy made the following utterance to the infant: “if your father or mother sends you on a message, do not refuse to go. But if a spirit (*ndi mmuo*) sends you, do not go.”[91]

Not all women engaged the services of midwives. There were those who became pregnant and carried it to full terms without consulting midwives. They took care of themselves based on general knowledge. In time of labor, available old women or other experienced women assisted in delivery. In polygamous families, the senior wives and other mothers in the household assisted with childbirth. In these instances, the only requirement was that these women have firsthand experiences of childbirth. Midwives and herbalists were not involved except in cases of complications or prolonged labor. Because pregnant women often went about their businesses, including trading and farming, some women went into labor on the way to or from their trading posts or farms. In this case, every woman on that path took off their extra wrappers and head gears and

---

90 Ibid., 293.

91 Ibid., 294.

formed an enclosure around such a woman.[92] This was to protect her from outside gaze and secure a private space for her delivery. Experienced mothers served as midwives in such a birth. Afterwards, mother and child were tended from neighboring households and then escorted home. At this time, there was inadequate transportation to ensure that a woman who suddenly went into labor was transported home to the midwife or *dibia*.

The Midwife's Medicine Bag

Figure 7: A midwife's pot of herbal medicine (Nsukka)

92 Ezechikwelu, c.94, Interview, Umuabu Village, Adazi-Enu, May 4, 2016.

The midwife administered specific herbs to pregnant women at various stages during pregnancy. There were *dibias* who also specialized on herbs for pregnancy and other gynecological issues. Some women who did not have midwives went to these *dibias* to get their herbs.[93] As the pregnancy advanced, women whose fetuses were suspected to be unduly large or who had *ukwu mkpa* (narrow pelvis) were given *Ahihara*, a leaf that reduced the child's weight and caused easier delivery. In Nsukka, the mid-rib of a plant, *Egbe* (Dracaena arborea), was added to the medications to increase its efficiency.[94] *Ogwu okpukpu ukwu* (medicine for the waist) was also prescribed for the expectant mother to strengthen her bones and reduce waist pain.[95]

In cases of prolonged labor, the midwife administered palm oil on the patient's abdomen to induce contraction. Her throat may be tickled for the same reason. The tender frond of the palm tree was inserted in the throat, contracting the abdominal muscle, and aiding in the baby's expulsion. In Northern Igboland, *Omu* (palm frond), *Akpa ido* (wasp bag), and *Akpaigogo* (a part of the palm fruit) were mashed together and administered to the woman to aid delivery.[96] Based on the Igbo belief that the characteristics of certain

---

93 Ibid.

94 Mary Ugwuanyi, Interview cited; Florence Odo, interviewed by Justina Eze, April 4, 2008.

95 Ogwo, Interview cited.

96 Ugwuole, Interview cited.

animals could be transferred, the wasp's aggressiveness was believed to be transferred to the medical properties of this mixture, therefore causing labor to speed up. The women also ate hot food that contained herbs and spices, like *Uda* (xylopia aethibicum) and *Utazi* (gongronema latifolium), believed to contract the uterus. These herbs not only aided delivery but also the discharge of the placenta. In dire circumstances, a *dibia* was invited.[97] Since indigenous medicine among the Igbo did not include any surgical expertise beyond minor operations involving circumcision, bone setting, and facial scarifications, complications requiring surgery were commonly fatal as the mother sometimes died of exhaustion before alternative approaches could yield results.

The breastmilk was also treated with close attention. Beyond the regular test administered by spilling some of it on the ground for ants to consume, some Igbo communities mixed the milk with herbs to ascertain its purity. It was a common belief that some breastmilk was bitter and not safe for the baby's consumption. Two leaves, *Atuiso* and *Uruedeala*, were mashed, mixed with the breastmilk, and spilled outside, under sunlight. If flies perched on the mixture, then the milk was certified as ready for consumption. This concoction was prepared by the midwife or another old woman

---

97 The traditional doctor in this case is a general term that covers the different branches of indigenous medicine. It is often used to imply an herbalist, doctor (dibia), and diviner. In some cases, traditional physicians are all these things at the same time. In other cases, they are simply a doctor, herbalist or diviner.

certified for the procedure. [98] New mothers were also fed fresh palm wine, a natural milky drink tapped from the palm tree, to spur the production of breastmilk.

After the birth of a child, other herbs were applied for infant's ailments. For babies that suffered from constipation, soap, made of burnt plantain leaves, palm oil, parts of the palm fruit, and other natural ingredients, was applied to the baby's abdomen to ease bowel movement. Children who suffered from fever were given a mixture obtained from *Akata*, a leaf whose properties were active against fever. Other childhood ailments like diarrhea and rashes were treated with home remedies or by the midwife. One such treatment for rashes was *ude aku (palm kernel oil),* which was rubbed all over the child's body as a regular lotion or to reduce fever and prevent convulsion. A small quantity was occasionally inserted into the baby's mouth. *Ude aku* was also used to treat the umbilical stump to prevent infection and ensure healing. It was a base for many traditional medical mixtures.[99]

To bolster spiritual protection for a woman during pregnancy or after birth, *Nsi ulu enyi*, a local black salt, was kept around her or licked occasionally to ward off any evil spirits or spiritual afflictions.[100] It was also believed to neutralize poison. Muringa

---

98 Ugwuole, Interview cited.

99 Ibid., Ogwo, Interview cited; Rosaline Ezekwem, c.89, Interview, Obe Village Adazi-Enu, May 15, 2016.

100 Ezechikwelu, Interview cited; Ibid.

leaves were used during pregnancy and after birth to regulate *obala ngbali enu* (blood pressure).[101]

Ejima and *Ogbanje*: Two Unwanted Outcomes of Childbirth

In Igboland up to the late 1930s, some birth outcomes were considered as sacrilege and spiritually unclean. One such case was twin birth (*ejima*), the birth of multiple babies at a time. This phenomenon has elicited multiple reactions in different African cultures. Among the Yoruba of Nigeria and Nyoro of Uganda, it was a cause for celebration.[102] In Igboland, however, it caused a different reaction. G. T. Basden says of the Igbo, "The birth of twins is a calamity of the first magnitude, and spells disaster for them and the unfortunate mother….; for a woman to bear more than one child in a birth is to degrade humanity to the level of the brute creation."[103] Though twin birth is now celebrated as a blessing, it was once considered an abnormality and a curse before the 1930s. Women who gave birth to more than one child were in some cases banished. In most circumstances, they were subjected to cleansing rituals (*Ikpu Alu*) and considered to

---

101 Ngozi Ikwueze, c.67, Interview, Orloto, April 2, 2016.

102 Philip Peek, *Twins in African and African Diaspora Culture: Double Trouble, Twice Blessed* (Bloomington: Indiana University Press, 2011), 1.

103 G. T. Basden, *Among the Igbo of Nigeria* (Gloucestershire: Nonsuch Publishing Limited, 2006), 50.

have soiled the land. Households where twins were born were also ostracized by their communities. The mothers were especially illtreated as the harbingers of evil. The twins were automatically sentenced to death.[104] They were put in earthenware pots and left in the community's *Ajo Ofia*, a large evil forest dedicated to deities, to die of exhaustion, starvation, or dehydration. New and tender palm fronds were tied on the pots' mouths to signify the spiritual or untouchable nature of the pot's contents. In few occasions, midwives connived in favor of a mother and killed one twin before anyone knew of the birth outcome. In this way, one of the babies was saved and the secret of a dual birth preserved.[105] People did not always resort to this outcome due to fear of spiritual retribution.

The rationale behind the practice of twin killing has been associated with a distinction between humans and animals. Animals were known for multiple birth, not humans; thus, a multiple birth among humans was interpreted as abnormal and offensive to nature. The Igbo made a clear distinction between animals and humans, and to act like an animal was a curse. Similarly, to be called an animal (*anu ofia*) was a form of insult. Twin killing died a slow but sure death, and by the late 1930s, it had mostly ceased due to the activities of missionaries.

---

104 Ikwueze, Interview cited.

105 Ibid.

Ogbanje, another unwanted outcome of pregnancy, was a situation in which a spirit child possessed a fetus. Upon birth, the baby died shortly after or upon attaining a certain age. This spirit child was eventually reborn to the family only for the newborn to die again. This birth-death cycle recurred until it was interrupted through rituals, mutilation, and exorcism. Families that experienced back to back death of babies suspected this to be a case of *ogbanje*. By a third consecutive death, families consulted diviners to determine if this was an *ogbanje* case and what could be done to break the cycle. To interrupt the child's reincarnation and prevent future death, the corpse of the dead baby was mutilated, sometimes severely. There were accounts of children whose ears or fingers were cut off and who were reborn in the same condition, only this time they did not die. The spirit world in which such children belonged was said to privileged purity. Therefore, mutilation of a member turned these spirit companions from such member.

During an interview at Adazi-Enu, a ninety-four years old man pointed to a mark on his head and told the story passed down to him by his parents and relatives of how each baby by his mother kept dying. When diviners certified this to be an *ogbanje* case, the baby was given a mark on the head. The old man was born with that mark on his head. "How do you explain that?" he said.[106] He also recounted the story of many families whose dead infants were mutilated and whose subsequent babies were born with

---

106 Ezechikwelu, Interview cited.

the exact scars. “Church people are quick to dismiss accounts to which they have no explanation,” he concluded.[107] He had other examples, including the story of a woman who was born with one palm missing. Out of anger and frustration over the torment of recurrent dead babies, the parent’s relatives cut off the baby’s palm before burying her. The next baby arrived with a stump where the palm should be. “This woman is still alive and you can go and verify this story,” he stated.[108] Apart from mutilation, families resorted to exorcism to expel the *ogbanje* spirit. Specific spiritual workers dealt with issues like this. A diviner was consulted to determine the worker that would successfully repel the spirit. This cycle of life and death could not be broken until specific rituals were performed. “This whole issue is hard to prove scientifically. One thing we know is that the child no longer died after these rituals,” an interviewee explained.[109]

Ogbanje was generally associated with waterbodies. The rituals performed were also mostly associated with water and water spirits, and had three variations. The affected family could decide to perform rites that would bind the child in the spiritual world and prevent it from dying at infancy in its next life. They may choose to banish this child

---

107 Ibid.

108 Ibid.

109 Chukwuma Opata, Interview, Department of History, University of Nigeria, Nsukka, April 8, 2016.

from revisiting them again, or they could perform rituals to prevent a living *ogbanje* child from dying.

After consulting a diviner, *Ibu ogu* was performed. In this ritual, the family provided broom sticks of various sizes that represented various *ogbanje* experts. The diviner placed the various effigies on several divination objects and then inquired as to which expert would perform the job successfully. The expert was then consulted and he/she listed the items to be used in the ritual. Objects for every *ogbanje* rituals varied, though there some components were constant. When the ritual involved preventing an *ogbanje* child from dying, items requested were things that represented life and death, as well as materials with spiritual significance. A small coffin representing death was obtained. A doll that corresponded with the baby's gender was acquired too. Two pieces of clothes, white and navy blue or black, were obtained. A kind of local rope, known as *ayaka*, was secured. The exorcist also got a type of local calabash - *ade*, cowrie shells, local powder (*odo*), *akaraka* (a large shell), *itanu* (tiny bells), local bracelets made of tiny bells, large bells, and *agba* (iron implements that serve as a chain/cuffs).[110]

The ritual items (except the coffin, the doll, *agba*, and *ayaka*) were put in the calabash and bound with the *ayaka*. They were again chained up with *agba.* The doll was put in the small coffin which was then nailed shut. The coffin represented the permanent burial of the spirit child and was taken to the river along with other ritual items. Part of

---

110 Ibid. Opata has done extensive fieldwork on this subject.

the ritual items for rites performed in the river included a small boat, a carved paddler, and a paddle. Live animals like cocks, hens, and white pigeons, and *ojiugo* (a type of kola nut), were also involved. The kola nut was thrown into the river, while the ritual expert watched the position of the kola nut as it fell in the river as this determined whether the sacrifice was accepted. The white pigeon was touched all over the child's body and then killed and cast in the river. Other animals were killed and touched on the ritual items. The head of the animals were passed four times over the child's head, representing the Igbo four market days. As this procedure happened, the exorcist uttered these words, "Forever and ever, I separate you from this spirit, just as this animal's head has been severed from its head." Afterwards, the items were placed in the river while the small boat, containing the little coffin, and the paddler were placed above the items. The boat sunk into the river to the spirit world, in accordance with the people's religious beliefs.[111] Afterwards, another set of kola nut was cast into the river to determine if the sacrifice was accepted. The child was bathed in the river and its clothes discarded. The child departed the river with those in the party without looking backwards.

---

111 "Canoe, Paddler, and Gifts," National Museum, Enugu; Opata, Interview cited. According to museum records, communities that experienced high infant mortality rates, either from epidemics or other unascertained causes, also performed a similar ritual involving a boat laden with gifts, and a traveler (an effigy) who took the gifts to the spirit world.

Figure 8: A type of chicken used in *Ogbanje* rituals. Note the short wings

For *ogbanje* rituals performed on land, the contracted expert had to find the burial site of the child's *iyi uwa* (oath of life). This could be some type of jewelry, a stone, *odo* (powder), or any other worldly item. After this item was recovered, the child's ties with the spiritual world was broken through sacrifices and other incantations. If the child was no longer an infant, he/she may be compelled to reveal the location of the *iyi uwa*.[112] The uncovering of the *iyi uwa* and subsequent atonements spared a child from returning to the

112 Ezechikwelu, Interview cited.

spirit world. In some cases, the *ogbanje* ritual was repeated at important moments in a child's life, such as marriage or childbirth.[113]

Figure 9: Items for *Ogbanje* Exorcism

The birth of a child was a celebrated moment in Igbo life. However, abnormalities were treated with trepidation due to beliefs in spiritual ramifications. Apart from twin births, other abnormal births proved fatal. In some communities, babies that did not cry

---

113 Ibid.

soon after birth were not accepted as human. The baby was not taken into the house until it had uttered its cry. In such cases, babies that failed to cry were condemned to certain death. Another cause for concern was a situation where a baby's upper teeth emerged before the lower ones. This was interpreted as a bad omen and such a baby suffered a similar fate as twins.

Conclusion

Every cultural system influenced experiences of health and medical care. These encounters changed as cultures adapted. Colonists and missionaries interpreted traditional midwifery, as well as other aspects of indigenous medicine, based on western standards. Views and practices that differed from or had no significance to western practices were labelled as magical and barbaric, even when they reflected the social and cultural values of the society. It is, therefore, necessary to approach all analyses of indigenous medical practices within a social context.

Contrary to popular colonial interpretations, practices in indigenous medicine were not just empty "heathen" rituals. Childbirth conferred on women certain positions within the spiritual and social space. It reflected the nature of kinship in Igboland and demonstrated the saying, "otu onye anaghi azu nwa (child rearing belonged to the entire community)". Rituals of pregnancy and childbirth reinforced social ties and relationships that offered social support to expecting parents and their babies. While biomedicine, including midwifery, focused on the body, traditional medicine measured health as a

pathological as well as social concern. Health and human life had social, moral, and religious undertones as well as a concrete physical existence.[114]

Notwithstanding, cultural practices are subject to change following encounters with foreign elements and advancements in technology. Traditional birthing practices underwent changes based on shifting economic systems, urbanization, and family dispersals. The local birthing institution came under its most severe attack during the colonial era. The increased activities of missionaries since 1900 divested birth of its ritual contents. As the Christian religion took root, sacrifices to deities as well as practices such as twin killings fell to Christian and government efforts and propaganda. This moment in history gave way to another form of birth that contended with traditional midwifery. It is to this new phenomenon, hospital birth, that we now turn.

---

114 Dennis Ityavyar, "Background to the Development of Health Services in Nigeria," *Social Science and Medicine*, 24: 6, (1987), 487; Horacio Fabrega Jr., "A Commentary on African Systems of Medicine," in *African Health and Healing Systems: Proceedings of a Symposium*, P. Stanley Yoder (ed.), Los Angeles: Crossroads Press, 1982, 250.

Chapter Three

"We want a doctor and nurse - God has emphasized the need": The Foundations of Biomedical Maternities in Nigeria

Introduction

"We rejoice to note that the Gospel is now being preached through medical missions. Our hospitals have all been used as the birthplace of many souls," a Church Missionary Society (CMS) medical mission report stated.[115] From the late nineteenth century, hospitals became a means of evangelism in Nigeria. At the turn of the twentieth century, this trend developed into a comprehensive missionary tactic. Birthing institutions were one the earliest targets. In the attempts to Christianize childbirth, missionaries took great pride in relocating birth to hospitals, hence the early attention given to this aspect of medical care by them instead of the colonial government.[116] Missionaries recognized the

---

115 CRL *Mercy and Truth: The Record of Medical Missions of C.M.S.*, Vol. XXV, 1921, 170-171.

116 Nancy Hunt shares the same opinion of mission-organized prenatal care programs in the Congo. See Nancy Rose Hunt, *A Colonial Lexicon of Birth Rituals, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999), 7.

central role of motherhood in many African settings, a position that they took advantage of. As reflected in the quote, "convert the mother, convert the child, and the entire community could thus be brought under Christianity," targeting young and married women was considered as advantageous to the Christian propaganda due to the women's access to local families and communities. [117] Missionaries believed that these women could reach other women in districts beyond the grasp of mission hospitals and also raise children in proper Christian ways. In time, widows were also recruited for training in Christian principles and maternity work. Afterwards, they were sent into communities where they could carry on mission maternity work without the encumbrance of marriage.[118]

Mission work in maternal healthcare was sparse until the twentieth century, following an increasing presence of female missionaries in colonial Nigeria. Maternity work expanded during this time and remained connected to evangelism until the 1940s

---

117 *The Mission Hospital: A Record of Medical Missions of the C.M.S.*, Vol. XXXII, 1929, 18; Michael Jennings, "'A Matter of Vital Importance': The place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39'," in Healing Bodies, *Saving Souls: Medical Missions in Asia and Africa*, edited by David Hardiman (New York: Editions Rodopi B.V., 2006), 229. See also 247.

118 *The Mission Hospital: A Record of Medical Missions of the C.M.S.*, Vol. XXXII, 1928, 171; *The Mission Hospital,* Vol. XXXII, 1929, 18.

when a growing interest in social welfare resulted in colonial government intervention and government's use of women as health propaganda tools. Missionary interest in using female converts as tools for evangelism restricted women's education to domestic sciences and limited the growth of a professional field of midwifery. With government interest in welfare work and women's health, however, more educational opportunities were opened to them and the contemporary field of midwifery became standardized. Traditional midwifery became positioned as "dangerous midwifery" while state and mission-sponsored campaigns against it mounted.

Missionaries and Medical Missions in Nigeria: Nature

Missionary enterprise in Nigeria was viewed as a civilizing mission to redeem lost and miserable souls. This ideology represented western perceptions of Africa. One of the institutions that came under attack not just in Nigeria but across Africa was the medical establishments, commonly regarded as the bastions of witchcraft, magic, and superstition. As an initiative concerned with saving souls, Christian missions viewed the local custodians of medicine and religion as obstacles to Christian work. Local medical establishments were seen as the bastion of witchcraft, magic, and superstition. Gradually, the provision of medical care became one of the avenues for conversion.

Prior to the twentieth century, the CMS - the largest missionary group to settle in Nigeria - did not utilize medicine as a major evangelical tool. Individual missionaries, instead, used scanty resources within their disposal to provide limited medical care in

their various locations. On the other hand, CMS's major rival, the Roman Catholic Mission (RCM), initiated medical care as a widespread instrument for evangelism, leading to an appeal by the CMS to their London headquarters for the initiation of widespread medical missions across Nigeria to offset RCM activities.[119] With this move the CMS abandoned its policy of not adopting temporal means for spiritual ends. They justified this new approach by hailing the work of mercy as a worthy Christian pursuit. Jesus's work on earth, they argued, included the saving of souls and healing of bodies.[120]

At the turn of the twentieth century, CMS missionaries clamored for increased and deliberate CMS involvement in providing medical care for the local population. They also challenged earlier policies of leaving medical care in the interiors to poorly qualified personnel. In a plea for more qualified personnel, a CMS evangelist, Rev. P. A. Bennett wrote,

> We very much need a doctor who could supervise our work and treat the more difficult cases. I know that it is urged…that people with limited knowledge do just as well in West Africa. To this plea, the answer to me

---

[119] C.M.S. G3/A3/0, *Henry Dobinson to R. Lang*, 5 May 1890.

[120] F. K. Ekechi, *Missionary Enterprise and Rivalry in Igboland 1857-1914* (London: Frank Cass, 1972), 77.

> which seems obvious, is, that the body of the barbarous savage is as faithfully and wonderfully made as that of the most cultured Brahman or most bigoted Mohammedan. We have a door of opportunity for medical work here such as, I believe, is not to be found anywhere else in the world…. Can you give us any help with drugs or dressings--at present, we have to pay for them ourselves or get by applying for help to personal friends?[121]

Rev. Bennett's treated more than two hundred patients weekly. A short distance away from Rev. Bennett in the Onitsha Medical Mission, there were 25,000 and 30,000 out-patient visits for the year 1900 and 1901, respectively.[122] Those who converted to Christianity returned to their communities to spread their new faith and the efficacy of biomedicine. Sentiments like Rev. Bennett's about the necessity for expanding medical

---

121 CRL, *Medical Missions Quarterly, Nos IX to XVI*, London: Church Missionary Society, Salisbury Square, E.C., 88. The figure for Bennett's patients was put at 200 per week in the CMS annual report for the Niger Missions. See CRL CMS M/C 2/1/7 (1898-1905), "Niger Missions, June 1900."

122 CRL, *Medical Missions Quarterly, Nos IX to XVI*, London: Church Missionary Society, Salisbury Square, E.C., 88. See CRL CMS M/C 2/1/7 (1898-1905), "Niger Missions, June 1900."

work were on the increase throughout the first quarter of the twentieth century and culminated in the extension of CMS medical missions across Nigeria.

These medical missions involved the recruitment and stationing of missionaries with basic or formal medical training in colonial territories where they doubled as medical workers and evangelists. Of the medical missions' objectives, a missionary wrote:

> Medical Missions do not exist merely to secure an audience for the gospel message, though when carried on in the right spirit, they will not fail to do this; nor do they exist merely as a philanthropic agency – they are such, and more than such. Their objective is to bring men, women, and children into the personal touch of Jesus Christ, and thus to spread His kingdom upon earth, to inspire the indigenous church with true ideals of Christian life and service; and to train the native Christians in a like ministry.[123]

Many patients who were admitted in medical mission facilities, even of a makeshift nature, were converted to Christianity and dedicated themselves to spreading the gospel

---

123 CRL *The Mission Hospital: A Record of C.M.S Medical Missions*, vol. xxxiv, 1930, 110.

in their various communities. This offered further opportunities for penetrating otherwise inaccessible locations.

The work of midwifery did not feature, however, as an important aspect of medical care in the early twentieth century. One reasonable explanation was the lack of a noteworthy female missionary population. Few European women accompanied their husbands to Nigeria and even fewer ventured out independently. There was, therefore, a shortage of female missionaries in many of the mission outposts. Since childbirth was viewed as women's affair, it was considered as an unsuitable field for male missionaries. Increasing numbers of female missionaries in the twentieth century, however, led to the capitalization on maternity services as a strategy for penetrating African households. According to Clement Chesterman, "no service rendered by a mission to a community is more appreciated and brings more vital contact with the people than does midwifery."[124]

Qualified medical doctors were in short supply across Nigeria, especially because very few English doctors enlisted to serve in the colony. To balance this shortfall and because of the desire to rely more on trained medical personnel, the CMS recruited European nurses, mostly women, for its missionary outposts. These female medical personnel began to advance maternity work. Nowhere else was their work more reflected

---

124 Clement Chesterman, *In the Service of the Suffering: Phases of Medical Missionary Enterprise* (London: Edinburgh House Press, 1940), 68.

during this earlier period than at Iyi-Enu Mission Hospital, formerly Medical CMS Mission.

The history of Iyi-Enu Hospital dates back to 1890, when it was first established as a dispensary in Onitsha with no active doctor. However, a definite medical mission, the Onitsha Medical Mission, started in 1898 with the arrival of a doctor. The dispensary and hospital was relocated to neighboring Ogidi, Iyi-Enu's current location, in 1907 after access to drinking water was secured in the town. An earlier attempt at finding a good source of water had failed in Obosi, the location of Rev. Bennett's dispensary.[125] After the hospital's relocation, a permanent structure, the Dobinson Memorial Dispensary, was erected at Ogidi, providing for two dressing rooms, "verandah" rooms, one casualty room for men and women respectively, a theatre, and the main dispensary room. Of Iyi-Enu's reputation, an English man touring Nigeria in 1927 reported, "[the work at Iyi-Enu] was one of the very best bits of medical works I saw in Nigeria at all."[126]

---

125 CRL CMS M/C 2/1/7 (1898-1905), January 3, 1898.

126 Ibid., "In Nigeria. Dated Achimota, 28 May, 1927," 3.

Figure 10: Old and new entrance to Iyi-Enu Mission Hospital[127]

[127] Older picture is culled from Royal Commonwealth Society Library, Cambridge (RCSL) CMS MED 1382, Entrance to Iyi-Enu Hospital.

Figure 11: Building Plan. Source: CRL M/F1/ N1/1, Iyi-Enu[128]

During the time of Iyi-Enu's establishment, no formal midwifery work or training was in place. What existed was an informal medical system supervised mostly by female

---

128 The dispensary was the earliest permanent structure in the hospital. A theatre was added to the original plan before the project was completed.

nurses and a doctor from England.[129] In Iyi-Enu as in other mission outposts, there was a shortage of doctors, who were also expensive to maintain - they were paid about $150, annually. The doctor at Iyi-Enu was, therefore, in charge of other locations and would travel from places like Asaba, west of the River Niger, to the medical mission in Iyi-Enu, east of the Niger. He also engaged in other necessary expeditions far afield.[130] Between 1903 and 1907, the CMS ameliorated the situation by sending more trained nurses, all women, to their medical missions on the Niger rather than take on the problems of securing more doctors. This increased presence of women in the mission resulted in the expansion of maternity work.

Women's medicine took shape with the addition of a women's in-patient ward to the Onitsha Medical Mission in 1900, under the initiatives of Miss L.M. Maxwell, Miss Warner, and Miss Wilson, all nurses at the medical mission.[131] This female ward received encouraging attendance from the surrounding villages and was a source of satisfaction to the nurses. From this time, the work in women's medicine grew. Soon, other nurses expanded their services to include that of midwifery. Notable among these nurses was

---

129 See CRL CMS M/FL1 N/1; CRL *The Mission Hospital*, Vol. XXXI, 172, 271-272; CRL CMS M/C 2/1/7 (1898-1905), 1898-1900; November 7, 1902.

130 CRL CMS M/C 2/1/7 (1898-1905), 1898-1900; April 8, 1902; November 7, 1902; 132-133.

131 Ibid., June 23, 1900.

Mary Elms whose work in midwifery and child welfare shaped the outlook of Iyi-Enu and other medical missions. By 1930, the medical mission at Iyi-Enu was dominated by women and was considered a "women's show" in official circle.[132] Their advancements in midwifery, women's healthcare, and child welfare resonated across the country in other CMS missions. By 1932, government had formally recognized Iyi-Enu as one of three centers for the training of midwives.[133]

---

132 CRL M/Y/A3/1, 1916-1933, "Extract from the Letter from Archdeacon Basden to Rev. H.D. Hooper, dated, Onitsha, July 29, 1932 (Despatch, Niger No. 24 of 1932).

133 Ibid., "Notes of Interview between Dr. Sybil K. Batley and Medical Committee, March 22, 1932."

Figure 12: Iyi-Enu's all-female hospital staff, 1926 [134]

Iyi-Enu hospital became a role model for evangelical maternal and child care. In a CMS discussion of missionary tactics, female missionaries were encouraged to make friends with local women as a way to further missionary work.[135] They organized meetings in which they addressed female Christian converts on health. Women in the

---

134 Source: CRL The Mission Hospital, Vol. XXXI, 1927, 173.

135 CRL M/E/L/1/1, "Medical Missions," 7. Missionaries in the North did not have this type of unlimited access to northern women due to religious, social, and political barriers.

villages were also instructed in domestic hygiene.[136] This proximity to local women created avenues for religious and health propaganda. The progress in maternity work was slow as majority of the cases handled by the hospital involved emergencies and difficult births. A large proportion of women still delivered at home with traditional midwives.

Figure 13: Partial views of Iyi-Enu Hospital's maternity wards, 2016

136 CRL *The Mission Hospital: A Record of C.M.S Medical Missions*, vol. xxxi, 1927, 171.

Figure 14: Iyi-Enu Hospital, Ogidi, 2016

One avenue of missionary propaganda, which became popular in the colony, was Baby Shows. These were competitions in which mothers displayed their babies to the community. The best-looking baby was then selected and the mother of the baby received

a prize. The shows were calculated to influence public opinion regarding hospitals, hygiene, and healthcare. It was also an instrument for attracting more indigenes to the mission hospitals. Though this practice became more widespread in the 1940s and was adopted by government health agencies, it was first initiated by missionaries. The earliest mention of it was on November 1926 when nurses at Iyi-Enu Hospital organized an "Ibo" Baby Show in which more than fifty mothers who gave birth at the hospital displayed their babies to the public. In return, they were each given gifts, such as soap, baby clothes, lotions, and cots.[137] Iyi-Enu Hospital's baby shows garnered much community interest in the work of the mission hospital. By 1940s, they became a common propaganda tool wielded not just by missionaries but by the health department to influence public attitudes towards infant care.

---

137 CRL *The Mission Hospital*, vol. xxxi, 172, 272.

Figure 15: Baby Show. Source: CRL ACC 444/Z1/35

In the western provinces of Southern Nigeria, the expansion of midwifery services tallied with the emergence of the *Aladura* religious movement (praying people) in 1929. Local converts left churches and hospitals in large numbers and flocked to *Aladura* rallies to seek faith-healing. In response, CMS doctors and nurses made an appeal to London for more medical workers. They recognized the need to counter *Aladura*'s faith-healing by expanding medical services in the area. They also interpreted the massive attention that

the movement attracted as depicting CMS's failure to provide such services among local communities. In their opinion, *Aladura* churches provided "cure for the ills of the body…, and welfare work (prenatal and postnatal) for the craving woman."[138] To this effect, the CMS in the western provinces issued a call, "we want a doctor, and we want another doctor, or nurse, to give instruction quite simply to the African woman who can pass it on to their sisters in their needs, midwives in the villages, a central hospital for the difficult cases. God has emphasized the need."[139] Analyzing the extent of medical mission work in Ekiti, the area most influenced by the *Aladura* movement, one missionary observed that there were just two missionaries and their wives within a 40,000 square-mile area, hence the dire need for evangelists, nurses, and doctors.[140]

The presence of Islamic caliphates and anti-missionary stance of the British administration in Northern Nigeria complicated medical work. Early British policy in the North stated that:

> In a matter solely confined with religion, the government does not feel justified in compelling a Moslem ruler to grant permission which but for government intervention he would refuse; that access to a mission-field

---

138 CRL ACC 716/F8, Church Missionary Outlook, vol. lix, January 1932, 3.

139 Ibid.

140 Ibid.

> which is gained by such means is in doubtful accord with the principals of Christianity, and it lies with the missionaries of their own efforts in the medical and education fields to win acceptance and to change hostility into friendship.[141]

However, rather than adopt the policy of non-engagement in religious coercion or non-intervention in religious freedom, the British government favored Islamic institutions at the expense of Christian missions, and curtailed Christian activities, often bullying missionaries and their local converts.[142] As Andrew Barnes observes, the colonial

---

141 Frederick John Dealtry Lugard, *The Dual Mandate in British Tropical Africa*, (London: William Blackwood and Sons, 1922), 594.

142 CMS G/3/A/9/0 *Map of Northern Nigeria*, 9; Andrew Barnes, *Making Headway: The Introduction of Western Civilization in Colonial Northern Nigeria* (Rochester: University of Rochester Press, 2009), 133; Shobana Shankar, *Who Shall Enter Paradise: Christian Origins in Modern Northern Nigeria, ca. 1890-1975* (Athens: Ohio University Press, 2014), 72, 78-79. Shobana Shankar observes also that British attitude towards missions and missionary work altered between 1931 and 1937, following growing interest in African health in the colony. G/Y/A/9/2, "Memorandum on Missionary Work in Northern Nigeria," 6.

government believed that it was in Britain's best interest to protect the predominance of Islam in the region.[143] The British administration found the bureaucratic system of northern Islamic caliphates useful for governance and did not wish this to be disrupted by Christian proselytizing activities.[144] The government routinely put large "pagan" territories under Muslim rulers and their emirates in other to take advantage of the emirate's social and legal machinery. Colonial officers feared that Christian activity might incite lower class northerners to rise against existing political hierarchy. "Denationalization as colonial administrators constructed it," Barnes asserts, "was a highly contagious disease. Christianity was its pathogen. Islam, however, could serve as its vaccine."[145] Open air evangelism was banned and District Officers, Residents, and other government agents closely monitored missionaries' contact with the local population to ensure the preservation of the status quo in the region.

---

143 Barnes, *Making Headway*, 103-106.

144 See Governor Frederick Lugard's acknowledgement of this fact in his letter to Dr. Manley in G/Y/A/9/2, dated 1912.

145 Barnes, *Making Headway*, 116.

Figure 16: Northern Nigeria. Source: CRL CMS G/3/A/9/0

Government harassment of missionaries and their Muslim converts was common. In Zaria in 1927, the British Governor of Northern Nigeria offered five thousand pounds to the CMS if they agreed to relocate the Zaria mission outside the city. By so doing, the mission would lose its footing among the Zaria people with whom it had gained such trust that residents of the city sent their Muslim children to live in mission houses and attend mission schools. Zaria was also a central and strategic location in the North. The

governor refused to allow the new Bishop of the northern diocese, Bishop A.W. Smith, to reside in the CMS mission house in Zaria for fear of missionary influence.[146]

The governor's policy was not new. Shobana Shankar writes that following the conquest of Kano in 1900, Frederick Lugard, the first High Commissioner of Northern Nigeria, restricted missions to non-Islamic communities outside the newly conquered caliphate. The Northern Nigeria governor in 1927 reinforced this position, stating that Kano, Sokoto, and Borno must be preserved as Muslim states. Missionary advancements of any kind were, therefore, barred in these cities until the 1930s.[147] He paid no consideration to the fact that some of these towns had a substantial non-Muslim population.[148] Borno Province, for instance, was known to be mostly occupied by non-Muslims.[149] Emirs were compelled to issue statements against Christian missions. In the

---

146 G/Y/A/9/2, [Letter from Bishop Court, March 25, 1927], 1-2.

147 Ibid., 3; CRL G/Y/A/9/0, 11; Shankar, *Who Shall Enter Paradise*, xvii.

148 CRL G/Y/A/9/2, G.T.M, "Memorandum on certain Matters concerning the Church Missionary Society's Work in Northern Nigeria," 3-5. See also CRL ACC 594/01, *Northern Nigeria Mission, Mission Policy in Hausaland*, 1.

149 G/Y/A/9/2, "Memorandum on Missionary Work," 7, 14. Borno was stated to have a non-Muslim population of 237,000. It is unclear how this data was arrived at by the CMS but every indication shows that Borno was not a major Islamic stronghold at that time (1920s).

case of the Emir of Zaria, for example, Resident Laing spent hours forcing the emir to make a statement against the mission, despite the emir's repeated statements that he had no problems with the missions and would not oppose their operation in his territory.[150] The Emir had, in 1905, assigned the CMS the land from which the government was attempting to eject them.[151]

Another example of bullying by colonial officers can be gleaned from the experience of Mallam Maina Ari, the King of Biu's son and heir to the Biu throne. Mallam Maina Ari, Dan Sarikin Biu (Son of the King of Biu), converted to Christianity during his tenure as a government college teacher in Kano. He taught his wife and servant his new religion, and attached himself to a missionary for instruction. His wife, who was of poor health, could not travel three miles to the missionary's house for coaching; therefore, the missionary's wife rode to Maina's house to attend and teach his wife. The Superintendent of Education hated these visits to Maina's house and ruled that no white person was to visit Maina's compound without his permission. The Superintendent and the District Officer summoned Maina over his conversion to Christianity, and afterwards sacked him from his teaching position. The Emir of Kano, the Islamic ruler of the city,

---

150 Ibid., "Church Missionary Society, Zaria, 20/4/1927," 3.

151 Ibid., "Memorandum on Certain Matters," 2.

counselled Maina that "The white man will not give the Throne of Biu to a Christian."[152] The treatment of Mallam Maina corresponds with Barnes assessment that the government sought to keep missions away from Muslims or any other northern groups with whom it hoped to collaborate.[153]

As the curtailments of mission work in Northern Nigeria increased, CMS officials proposed that,

> We should appeal to the conscience of England. It would mean a definite crusade in Parliament through the country. The Government policy in Northern Nigeria makes for stagnation. It must do so when it is practically pro-Moslem. The French allows missionaries in areas farther afield and quite, if not more, Moslem. We have remained quiet under these restrictions for many years and it has increased in severity rather than grow less.[154]

---

[152] G/Y/A/9/2, *Northern Nigeria Missions*, "The Case of Mallam Maina Ari, Dan Sarikin Biu, Nigeria," 10. For more information on this subject, see C.R. Niven, *Nigeria: Outline of a Colony* (Wisconsin: Thomas Nelson and Sons Ltd., 1946), 86-87.

[153] Barnes, *Making Headway*, 114.

[154] Ibid., "Letter from Bishop Court," 4.

To accommodate government wishes, missions in the North generally refrained from preaching in market places, public thoroughfares, and the vicinities of mosques.[155] Missionaries also complained about the severe lack of apathy in medical and missionary work among locals who they stated would not attend missionary outposts or hospitals unless there was an immediate opportunity for material gain.[156] They were also constantly under suspicion of harboring ulterior motives due the peoples' difficulty in separating the purposes of Christian health work from the political undertones of government propaganda.[157] Where hospitals were established as an example of Christian charity and to attract admiration of the northern people, care was taken to create a distance between medical facilities and churches in order to avoid the apathy that may ensue, should a church be seen as affiliated with a facility. Patients who proved open to the gospel were quietly directed to small meetings in private homes where they would be exposed to further gospel teachings, away from prying government eyes.[158]

---

155 CRL G/Y/A/9/2, "Memorandum as to Open Air Preaching, Mission Sites, & in the Moslem Emirates of the Northern Provinces."

156 CRL CMS/M/C Z/1/7, 1898-1905, 133.

157 G/Y/A/9/2, G.T.M, "Memorandum on certain Matters," 249.

158 G/Y/A/9/2, 249.

The Northern Nigeria Medical Missions, formerly Hausaland Medical Missions up to 1909, also suffered setbacks due to the presence of purdah, a religious and social custom of seclusion that restricted women's personal, social, and economic activities. Other local practices that prevented the free mingling of men and women, even in medical settings, also interfered with medical work. Thus, not only did missionaries have limited access to women, but medical men, who dominated health work at the time, were not allowed to treat women.[159] In some cases, female missionaries and medical workers could not enter a house if the male head of the household was present.[160]

Though missionaries hoped to use works of charity, such as education and healthcare, to convert northerners, the outcome was different from the rest of the country. By stunting missionary advancement, government policy in Northern Nigeria affected medical work and the education of potential local staff in the region up to the 1930s. Compared to the rest of Nigeria, attempts at western education were feeble and had little impact.[161] According to the CMS, "Northern Nigeria…is left in mental and spiritual stagnation by a group of men whose mistaken ideals are hopelessly selfish."[162] The almost empty dispensaries and hospitals in Northern Nigeria could not compare to

---

159 CMS/M/C Z/1/7, 1898-1905, 133.

160 Shankar, *Who Shall Enter Paradise*,

161 CRL G/Y/A/9/2, "Memorandum on Missionary Work," 12.

162 Ibid., "Church Missionary Society, Zaria, 20/4/1927," 4.

attendance in Southern Nigeria dispensaries. Records from Zaria during the period of 1901 and 1902 showed that patient-attendance in dispensaries was very irregular and quite the trickle while attendance in the medical mission at Onitsha, Southern Nigeria, during the same period was 30,000 patients.[163] By 1929, the records had hardly improved. The in-patients in the Zaria Medical Mission were one hundred and thirty-eight only.[164]

Female Education and the Advancement of Midwifery

The most effective tool adopted by missionaries for Christianization was western education. Since colonial rule emphasized the domestication of women, the type of education afforded them differed from that of men. Women's education aimed at grooming proper housewives and mothers rather than competitive professionals.

This one-dimensional interpretation of women in Nigeria as wives and mothers, which was influenced by nineteenth century Victorian notions of womanhood, eroded their precolonial economic and socio-political power, and disadvantaged them in the areas of skilled training and the civil service.

In line with missionary objectives for female education, training centers were established to groom young girls on lifestyle and carriage appropriate for potential wives

---

[163] CRL CMS M/C 2/1/7 (1898-1905), 1898-1900, "Niger Mission, 1902."

[164] CRL Mission Hospital, Vol. XXXIV, 1920, 153

and Christian mothers.[165] In some cases, the girls were taught enough reading skills to study the bible. The rest of the curriculum focused on needlework, "African cookery, laudry [sic] work, housewifery, and the mothercraft." [166] At first, such schools were informal and the work of individual female missionaries. While some of the schools were established independent of the government, their existence was lauded in official circles. Regarding such institutions, a colonial agent stated: "Normally speaking, an education department would not consider such work under them, but it is real education in this place and alive."[167] Where female education lacked a curriculum centered on cookery, laundry work, and infant care, as in Ibadan in 1933, colonial administrators questioned such education. In their opinion, the future of these female students was marriage and not much else.[168] Formal Domestic Science schools, which provided a "female-centered"

---

165 CRL M/Y/A3/1/1916-1933, 2.

166 CRL G/Y/A/9/2, *Northern Nigeria Missions*, "…in Nigeria, dated Achimota, 28th May 1927," 2.

167 Ibid. See also Wellcome Library, London (WL) CO 593, Southern Nigeria, No. 39 of 1908, "Annual Report on Education Department for the Year 1907, 208.

168 National Archives, Ibadan (NAI) OYO PROF 1/1129, *Domestic Training for Girls-Suggestions as to*, 3.

training for women, became standardized across Nigeria by the colonial government in the 1930s. [169]

The domestic science education provided for girls was the most instrumental way that missionaries altered the structures of local households. Missionaries seized this opportunity to remold local women into their own standard of womanhood. Local cultures and practices also came under attack as a clear correlation was drawn between observances associated with traditional institutions and idolatry. Missionary education began a dismantling of indigenous social and therapeutic structures.[170] Specific campaigns were targeted at traditional midwives, who were described to new Christian converts as the harbingers of evil not worthy of association with Christian women. Educated men and women were also trained to look down on traditional practices as inferior. Traditional midwifery and other local practices were weighed based on European standards.[171] Christians were swayed from indigenous medicine, and those who recognized the efficacy of traditional doctors visited them in secret.

---

169 Up to this time, mixed schools mostly did not include the female curriculum. There were few female teachers to implement such trainings in these schools.

170 As chapter five shows, this assault was not fully successful but resulted in new and renegotiated identities.

171 NAI OYO PROF 1/1129, 38.

In Northern Nigeria where there was limited missionary access to local women, female education during the early colonial period centered around former enslaved women who had come under missionary care. Following British conquest of the North and the crippling of the northern slave trade, the British administration opened homes for freed slaves in the region. In 1908, these homes were handed over to missionaries. They had mostly female inhabitants, who formed the bulk of early Christian converts. These individuals easily adopted Christian lifestyle and mostly got married to other male Christians. A significant portion of northern women remained inaccessible, however.[172]

Biomedical Maternal and Infant Care takes Shape

With growing interest in maternity works due to the successes and increasing popularity of prenatal clinics, they expanded beyond existing capacity. Local women who had reputations as good Christians were identified and sent out by church councils to receive training in maternity work.[173] The growing interest in maternity work resulted in a desire to improve the level of education available to local women. Until then, the medical sector, including nursing, was dominated by men. A CMS missionary observed in 1900 that their "little hospital" on the Niger employed four or five medical helpers, all

---

172 Shankar, *Who Shall Enter Paradise*, xvii-ix.

173 CRL *The Mission Hospital: A Record of C.M.S Medical Missions*, vol. xxxii, 1928, 171.

of them male. Dressers were men as well.[174] Even the professional field of nursing, which was predominantly female in the UK from the late nineteenth century, favored men over women. Nurse Dorothy Ross reported in 1924 that local nurses in Iyi-Enu Hospital during that year were all male.[175] Where female nurses existed, their practices were restricted. In 1929, female nurses were limited to postings in female wards, which implied that male nurses were in sufficient numbers to preside over non-female wards.[176] Miss Lee Pronger, a nurse, writes in the same year that, "for the work in the men's ward and the dispensary, male nurses are trained, while for the women and children we teach African girls."[177]

As midwifery and infant welfare services expanded under missionary supervision, it gained increasing attention in government circles in the late 1930s. During this period, there were concerns about disease spread and infant/maternal mortality rates. Government observed that tropical conditions exacerbated maternal and infant mortality,

---

174 CRL *Mercy and Truth: A Record of C.M.S Medical Missions*, vol. III, 1899, 216-217.

175 CRL CMS ACC 780/F1, Dorothy Ross, *The Pattern of a Life*, 19.

176 British National Archives, Kew (BNA) CO 583/248/6, Mission Activities "African Missions", *Training of Subordinate Staff in the Medical Department*, 2.

177 CRL *The Mission Hospital: A Record of C.M.S Medical Missions*, vol. xxxiii, 1929, 18.

creating a disproportionately high ratio of maternal-related deaths in comparison to the general death rates.[178] Colonial policies, hence, advocated for emphasis on preventive medicine, with particular focus on the health of mothers and children. This new large scale interest in maternal and infant mortality led to deliberate efforts by the government to increase the number of female staff in the medical sector.[179] The increase was calculated to improve government's ability to manage the health of women and children. Associations can be made between this new interest in women's health and the numerous medical advancements that occurred in Britain during World War II. The colonial government paid more attention to tropical diseases, such as malaria, during this time and attempts were made in the colony of Nigeria to improve the health of mothers and children.[180]

Like missionaries, government understood the critical position of women and saw them as effective agents of social and health propaganda. To this end, the lack of adequate educational facilities and negligence of female education were reevaluated. A government agent who favored broadening female education argued that:

---

178 NAI J/1/a, *Medical Policy in the Colonial Empire*, 2.

179 Ibid.

180 Some relevant books include: Anne Hardy, *Health and Medicine in Britain Since 1860* (Hampshire: Palgrave, 2001); H. Jones, *Health and Society in Twentieth Century Britain* (London: Longman, 1994).

> As I said in my Annual Report, I believe that girls' education is now at a critical stage, and if financial reasons do not forbid, that the time has come for a real advance. It has become clear to me that the people wish education for their girls, and are willing to send them to school.[181]

Women were provided with more educational opportunities than had previously been available to them so that they could extend their knowledge to their communities.[182] From 1946, government progressively partnered with missions in the provision of maternity care following the realization that setting up separate institutions would result in manpower stretch and under-staffing due to the shortage of trained midwives. They also recognized that their social welfare objectives and those of the medical missions were complementary. Therefore, mission work in the medical field was considered an extension of government scheme.[183] Government provided funding and supervision for

---

181 NAI OYO PROF 1/1129, 41.

182 See NAI J/1/a, 3.

183 National Archives Enugu (NAE) MINHEALTH 30/1/253, "Co-operation with Voluntary Bodies"; NAE MINHEALTH 30/1/253, "The Relationship between Government and the Missionary and other Voluntary Societies regarding the

church-owned maternity institutions and training centers, and made efforts to expand existing training centers to accommodate larger intakes.[184] Thus, the 1940s was a defining moment in the development of maternal and infant health in colonial Nigeria.

No reasonable separation existed between missionary and government agenda for women. In conjunction with missionaries, the administration hired traveling Lady Doctors for itinerant work across the districts to attend the medical needs of women and children. This idea of travelling female doctors was first initiated among the Igbo around 1932 by the colonial governor, Donald Cameron. This action resulted from a proposal to work with missionaries on the matter of maternal and infant welfare.[185] By 1946, the work of travelling female doctors had burgeoned and resulted in the opening of numerous maternity homes and infant welfare centers.

The expanding field of maternal healthcare also increased the number of local women hired as infant welfare workers and nurses.[186] Government considered it urgent that more women be recruited in these fields than existed pre-1946 because, "the nurse…should be selected and trained with a view to her being able not only to care for

---

Development of Medical and Health Services;" "To the Secretary of States for the Colonies," London, 22 January, 1948.

184 Ibid., 169.

185 CRL M/Y/A3/1 1916-1933, 1-2.

186 NAI CSO 26/3, *Infant and Maternity Work in Nigeria II*, 133.

the sick but to promote health education and help people to improve their conditions of living."[187] Like missionaries, the administration now acknowledged the extent of female influence on the community.

The professional field of midwifery also witnessed some advancements during this time. In Ondo Province, missionaries proposed a scheme in which most African dressers, almost always male, were to be replaced by women who doubled as midwife-dressers. In this way, communities would simultaneously have the services of a dresser, in charge of first aid, and a midwife. These midwife-dressers would be attached to dispensaries which would now have a few beds added to them for maternity cases.[188] As the level of female education expanded, a missionary remarked that, "more applications have also been received from native girls, who have acquired a higher standard of education than previously in order that they may train as nurses."[189]

The colonial administration embarked on the standardization of exam requirements for medical workers across the country in the post-war era. Prior to this standardization, two midwifery training certificates, Grade I and Grade II certificates, existed in the colony. Qualification as a candidate for Grade II midwifery in the provinces of Southern Nigeria, especially the Igbo territory where the level of female

---

187 Ibid., 5.

188 NAI MH (FED)/1/1/4075, *Infant Welfare Center, Ondo Province*, 2.

189 CRL *The Mission Hospital*, vol. xxxi, 272.

education was higher, required a Standard 6 certificate, a level of education not commonly attained by the general populace.[190] Training lasted for three years.[191] In the northern region where female education was still in its infancy as of 1942, requirements were much lower and made to suit local circumstances.[192] The table below displays an example of the lower requirements for the North:

---

190 NAE MINHEALTH 6/1/22, "CMS Midwifery Training School, Ref. No. E.1.21/34." Note that the standard of education was not equivalent to what it is today. Young adults rather than children acquired the Standard 6 certificate (easily recognized today as Elementary Six) at the time. Thus, one should not think that midwives were by implication teenagers or pre-teens.

191 NAE MINHEALTH 30/1/253, "Medical Development Owerri Province," 8.

192 NAI MH (FED)/1/1/4075, 9.

Table 1: REQUIREMENTS FOR GRADE I AND II MIDWIFERY IN ILORIN, NORTHERN NIGERIA [193]

Grade I	Grade II
Must have had a good education, passed Middle IV Secondary School or equivalent.	No particular standard of education required - Syllabus states, "may be quite illiterate".
Must train for at least three years. Must have delivered at least fifty women and attended at least fifty lectures.	Must have been under instruction for at least six months and delivered personally twenty women.
Must be willing to serve in any part of Nigeria. Need not be "local" inhabitant.	Should be local women by birth or long residence, taught and registered to practice locally.
Written paper required as well as oral and practical examination.	Examination entirely oral and practical. No paper required.

As female education improved, a more unified requirement for Grade II midwifery was proposed by the government:

193 *Ibid.*

a. That they shall have passed standard vi. (elementary school) and that they hold a School Leaving Certificate to this effect. Must be able to understand English.

b. That they are at least sixteen years of age.

c. Need not be local inhabitants but must be able to speak the language of the patients among whom they will work.

d. May sit for the CMS examination at any time after the completion of their second year provided that they have reached examination standard.

e. Must be willing to stay on for at least a year after they have qualified [This was to circumvent married students leaving immediately after their training].

f. Must be willing to go where sent provided it is in the Area under which they are registered.

g. Must have attended at least fifty lectures and delivered at least fifty women, before taking the examination.[194]

The new general requirement for qualification as a midwife affected Northern Nigeria adversely because few candidates could pass the nursing and midwifery exams, and even

---

[194] MH (FED) 1/1/4075, 6.

fewer could take advantage of scholarships for nursing and midwifery candidates. For instance, only one in six candidates who registered at the Wusasa Training Center, a major nursing and midwifery training center, was anticipated to pass their exams.[195]

Despite the attempts at improving women's access to education, the prospect of marriage, still perceived by colonial officers as women's future, cast a shadow on their employability in professional medical sectors. There were constant concerns in missionary and official circles that the trained female nurses and midwives would marry and be lost to medical and mission work. Officials believed that unmarried women would quit their work to pursue marriage after a few years. In some cases, women who were unlikely to get married, for instance twins, were recruited. Though the colonial government abolished the killing of twins after much effort by missionaries, some families still killed one twin at the time of birth and allowed only one to live. Where the infants survived, some stigma remained attached to them even up to the 1930s. Female twins were undesirable candidates for marriage as no one wanted to a victim of any spiritual backlash or be associated with a taboo.[196] Alongside widows who were not

---

195 G/Y/A/9/2, 251.

196 Twins were considered a taboo in parts of Nigeria, especially in Igboland. See CRL M/Y/A3/1 1916-1933, *Notes of Interview Between Dr. Sybil K. Batley and Medical Committee*, March 22, 1932, 2; For more information on missionary actions against twin killing, see CRL, *Mercy and Truth*, Vol. 9, 6-7.

encumbered by the desires of a husband, twins were therefore a ready source for recruitment.

According to the medical officer at Akure on why Grade II midwifery certificates should not be replaced by Grade I certificates:

> Native law and custom, and public opinion deter girls from the unmarried state. Most of the girls who would and do take up this work are betrothed in infancy or before they leave school and a prospective husband might be willing to wait 4 to 5 years before claiming his wife.[197]

The officer's observation reflects the ways that women's prospect of marriage shaped the options available to them. The instability which marriage was seen to have on women's work influenced their limitations to the lower Grade II status. Women's attention was reported to shift from work to marriage and motherhood after about two to three years of service.[198] In some quarters, however, there were sentiments that marriage could mean the furtherance of mission work. Married women could extend their knowledge to their new families and the remote communities to which they sometimes settled with their husbands. These interactions would in turn undermine the practices of traditional

---

197 NAI MH (FED)1/1/4075, *Infant Welfare Center, Ondo Province*, 1.

198 Ibid.

midwives in these communities. The contributions of these married midwives to the Nigerian Medical Service would not be felt until the 1950s when they opened private practices in urban and rural residences, thereby making midwifery services accessible to a larger proportion of the population than was previously reachable.[199]

In 1946, the colonial regime initiated policies to decrease the number of European staff in Nigeria's medical department and replace them with more African staff due to the belief that local recruits understood the community's lifestyle better than foreigners. [200] They would best advance the colonial and Christian propaganda. A ten-year plan was developed in 1947 to expand educational and medical institutions, and improve local participation in them.[201] However, Grade I midwifery remained dominated by Europeans until the 1950s, perhaps because few African women possessed the educational qualifications for Grade I status during this period.[202] The professional field of midwifery was also relatively new, compared to other medical sectors in Nigeria, and did not have

---

199 For further information, see CRL CMS ACC/165/F27, *The Private Owned Maternity Home in Nigeria*, 1-2.

200 NAE MINHEALTH 30/1/253, "A Bulletin for Community Nurses in Eastern Nigeria," 37; NAI J/1/a, 3-4.

201 Shankar, *Who Shall Enter Paradise*, 111.

202 Ibid.

adequate qualified African staff with required years of experience for the Grade 1 certificate.[203]

In the provinces of Northern Nigeria, maternal and infant welfare work as well as the recruitment of staff was slow and problematic due to the lack of "continuity of staff," a problem that the government identified as peculiar to the North.[204] Health workers did not remain at their posts long enough to gain the confidence of the people with whom they worked. Also, due to the poor advancement of western education in the largely Muslim north as well as the limitations on missionary work, a considerable lack of qualified local medical staff existed in the region. There were insufficient indigenes, male or female, who could advance the various health and educational schemes being adopted in other parts of the country.[205] Doctors argued in 1942 that it was impractical to launch social medicine schemes, such as the Traveling Lady Doctor or other projects that involved community outreach, because the region was not at par on medical advancement

---

[203] The preponderance of Europeans in Grade 1 midwifery was consistent with colonial policy of hiring European personnel in higher positions while paying African workers with equivalent qualifications lesser and posting them to less important posts. See NAI J/1/a, 6.

[204] Ibid., "Minutes by His Honour, The Acting Chief Commissioner, Northern Provinces (MR. J.R. Patterson D.M.G.)," 16.

[205] Ibid., "Minutes by His Honour," 16-17.

with the rest of the colony and was not ready for such schemes. There was great difficulty, not experienced elsewhere in the colony, in securing female trainees due to the early stages of female education in the 1940s.[206]

Female attendance at northern hospitals was also poor. While the male wards were constantly filled, with excess patients accommodated on the floor, the female wards usually had about two women. A 1942 report regarding the CMS Medical Mission, Wusasa, Zaria, which was the center for medical work in Dutsan Wai, Maska, Bakori, Chafe, and Katorkwoshi, observed that few Hausa women attended the hospitals for birth except during extreme cases of abnormal labor and the failure of traditional medicine.[207] This situation, according to a medical missionary, was because, "Hausa women are terribly ignorant and frightened. Many husbands keep their wives shut up in the compounds. We so long to reach these poor helpless sufferers, but we can only go at their invitation, and prejudice is hard to overcome."[208] Another government worker commented that:

> In Northern Provinces the attitude of the people is entirely different and progress where it exists is extremely slow and is only attained as a result

---

206 NAI J/1/a, 30.

207 CRL M/M3/3/1942/3, *Medical Mission, Wusasa, Zaria*, 1, 3.

208 CRL *The Mission Hospital*, xxxvi, 115.

> of the most painstaking and persistent efforts owing to the extreme conservatism which pervades Fulani, Hausa, and pagan communities. Slightly better progress in child welfare work is noticeable, but here again there is no evidence of the enthusiasm which is so gratifying among the peoples of the South.[209]

These assessments point to the challenges that Islam and early colonial policies in the North posed for medical mission work. Since hospitals frequently doubled as branches of Christian missions, many Muslim men were unwilling to expose their women and children to Christian propaganda. These setbacks to missionary work led to slower implementations of policies in the North.

The northern dilemma was compounded by the fact that male and female health workers of southern origin were not readily accepted by northern peoples for what government officials termed "political reasons."[210] It is not clear what "political reasons" refer to, but this is possibly an allusion to the growing political tensions between northerners and southerner minorities in the north since the late 1940s.[211] Thus, European

---

209 Ibid.

210 Ibid., 31.

211 In *Who Shall Enter Paradise,* 123-128, Shankar discusses radicalization and tensions in the north between northerners and southern minorities.

officers occupied the primary medical posts as they were more acceptable to the people than southern medical workers. This meant that while government tried to promote the inclusion of Africans in more prominent positions in hospitals and maternities across the colony, Northern Nigeria developed at a different and much slower pace, and witnessed an increase in its European staff due to the need for teaching and guidance.[212] It was not until the late 1940s that the North experienced advances in female education and female hospital attendance than were previously recorded.

CONCLUSION

Medicine is a great means of control. Women's medicine proved to be an even greater propaganda tool, as one arm of the colonial infiltration – missionaries – realized. While the colonial administration ignored women completely, robbing them of whatever agencies that they exercised within their cultures, Christian missionaries recognized the tactical position of women in the advancement of their evangelical cause. It was as though their eyes were opened to the African adage, "educate a woman and you educate the whole nation." Midwifery and childcare work was seen as a way to penetrate local communities, and through local women, advance Christian and health propaganda. Before long, the colonial administration embraced this missionary tactic of utilizing women as propaganda tools. Where they had once denied women proper education and

---

212 CRL *The Mission Hospital*, xxxvi, 31.

instead relegated them to the place of housewives, they now clamored for greater female education. Health and recruitment policies were launched that now focused on women. In place of an all-male dresser corps, female midwife-dressers emerged. Advocacy for the recruitment of more female, as opposed to predominantly male, nurses became widespread.

By the 1940s, more female nurses and midwives had been recruited to carry the torch of hygiene and disease control to the depths of the colony. The professional field of midwifery, considered as women's medicine, also became solidified during this time. All regions except Northern Nigeria witnessed significant female education and increased presence of women in the health sector by the World War II era. The North was bedeviled with the outcome of tension between two arms of the British empire – government and missionaries. It was not until the late 1930s that northern territories hitherto closed to missionary work were opened. In the end, the account of biomedical midwifery and maternal health in Nigeria is that of the utilitarianism of religion. As a missionary pointed out, "the people refuse to come if they cannot get anything from us."[213] This idea also played out in the successes and strategies of African Independent Churches under the *Aladura* movement.

---

213 CMS/M/C Z/1/7, 1898-1905, 133.

Chapter Four

"You Shall Deliver like the Hebrew Women": African Independent Churches and a separate Birthing Space

Introduction

Just as African deities gained worshippers through belief in the advantages that their worship conferred, the Christian religion in colonial Nigeria attracted adherents due to the gains that western education and medicine proffered in a rapidly changing society. The story was similar for the *Aladura* Movement, an indigenous Christian movement that emerged in Western Nigeria in 1929. The Movement gained momentum as a result of deep-seething feelings of oppression by Nigerians over their subjugation in mainstream religious circles.[214] It also offered a promise of relief from the epidemics that plagued

---

[214] A similar movement emerged for the same reasons in the country's Niger Delta region in 1915 under the leadership of Garrick Braid, though it had no enduring effect (See CRL H7/B/6/5/14). There were equivalents of the *Aladura* Movement in former Nyasaland (Malawi) under John Chilembwe between 1900 and 1915 (see Jane Linden and Ian Linden, "John Chilembwe and the New Jerusalem," *The Journal of African History,* Vol. 12, No. 4 (1971): 629-651), and the 1921 religious movement of Joseph

Nigeria's Western Region since 1918. The African Independent Churches (AICs) that emerged from the *Aladura* Movement challenged traditional and biomedical practices and created a healthcare structure that was based on faith-healing. Despite their opposition to biomedicine and traditional medicine, they reinforced cultural notions of health and diseases. To varying extents, their organizational patterns reflected influences from the western missionary churches from which their leaders emerged. In the end, however, their religious healing space moved them outside the influence of colonial propaganda tools, such as missionary institutions and medical centers.

This chapter examines faith-healing in Nigeria from the 1920s up to 1960, with specific attention to the advent of faith-based midwifery and the religious birthing spaces that were set up for pregnant women. I evaluate the circumstances that precipitated the

---

Kimbangu in Belgian Congo (Congo DRC). For *Kimbanguism*, see Aurelien Mokoko Gampiot, "Kimbanguism: An African Initiated Church," *Scriptura: International Journal of Bible, Religion and Theology in Southern Africa*, Vol. 113, (2014): 1-11. See also Philip Jenkins, *The Next Christendom: The Coming of Global Christianity* (Oxford: Oxford University Press, 2002), 48-50 for the movement of William Wade Harris in Ivory Coast. These religious movements varied in their political nature and adherence to faith-healing.

foundation of AICs and the *Aladura* Movement. I also highlight the influences of indigenous notions of health and illness on *Aladura* healing spaces.

Faith-Based Midwifery: A Glimpse into Early Beginnings

The *Aladura* Movement was the most enduring independent church movement in Nigerian history. From its early moments, *Aladura* churches made an impact in Western Nigeria in the area of maternal and childcare. According to official records, out of 7,656 *Aladura* converts in 1931, 1,596 were men while 6,060 were women.[215] A colonial agent touring ten Yoruba towns where the foremost *Aladura* church, Faith Tabernacle, was located observed that women outnumbered men in all these locations. These statistics play a crucial role in understanding the strides that the movement made with regards to maternal healthcare.

Part of the movement's attraction to a predominantly female membership was the prospect of relief from barrenness and other illnesses. At the time of the movement, Western Nigeria recorded an unusually high rate of infant mortality. In Lagos, for example, the documented infant mortality rate per 1000 babies was 281 in 1922 and 378

---

215 NAI OYO PROF 1 662, *The Faith Healer-Babalola and the Faith Tabernacle otherwise known as The Aladura Religious Movement-Operation of in Oyo Province.* See also J.D.Y. Peel, *Aladura: A Religious Movement Among the Yoruba* (London: Oxford University Press, 1968), 95.

in 1926.[216] Death of infants under the age of one was 809 in 1922 as opposed to lower rates in other parts of the colony.[217] These statistics were not always true representations of local circumstance as the high numbers may simply signify the increasing popularity of hospital birth and the transfer of more complicated cases to the hospitals, hence their record in the medical report. The recorder of the above report commented that the death rate may have been inflated because it was much higher than other parts of Nigeria. Notwithstanding, the *Aladura* Movement's appeal to women whose main concerns were childlessness, alludes to a problem regarding infant mortality.[218] Concerns about childbearing may be connected to the waves of epidemics that besieged Western Nigeria, the location of the crucial port city of Lagos, since 1918.[219]

---

216 WL ANN REP WA28 NH5 N68 1922-1925, *Annual Medical and Sanitary Report for the Year 1922, 19*; WL ANN REP WA28 NH5 N68 1926-1928, *Annual Medical and Sanitary Report for the Year 1926*, 37.

217 WL ANN REP WA28 NH5 N68 1922-1925.

218 Ibid.

219 *Lagos Standard*, 9, 23 October, 1918; "The Recent Epidemic from an Astrological Standpoint," *Lagos Standard*, 1 January, 1919; University Library (UL), University of Illinois at Urbana-Champaign, *Colonial Annual Reports, No. 1315, Nigeria*, "Reports for 1925," 10, 12.

Emphasis on pregnant and barren women recur constantly in colonial records of *Aladura* activities, pointing to fertility or infant mortality issues for women in this area during the 1920s and 1930s. A CMS Archdeacon who commented on the *Aladura* observed that Prophet Joseph Babalola, the head of the movement, gave particular consideration to women's maternity needs. In the Archdeacon's words, Babalola offered "the good news for the soul; cure for the ills of the body; and knowledge and welfare work (pre-natal and post-natal) for the craving woman…. The people want the Christian gospel in this threefold aspect"[220] In his opinion, part of Babalola's popularity derived from the belief that his revival meetings facilitated pregnancies and addressed infertility.[221] Barrenness or the inability to have multiple children was considered as a spiritual affliction that must be remedied.[222] While Christian missions and biomedical hospitals did not satisfy this spiritual component of health and fertility, the *Aladura* Movement filled the vacuum by addressing peoples' fears and superstitions, and offering them protection from malignant spiritual forces. The Movement was a product of the socio-cultural milieu in which it was born.

As part of the *Aladura* revival meetings, Babalola arranged special prayers for pregnant women and recited specific psalms to invoke protection for the women.

---

220 Cadbury Research Library (CRL) CMS ACC 716 F8, January 1932, 3.

221 Ibid., 2.

222 CRL H7/B/7/80, *Africa*, "Mainly about Women in the Church of the Lord," 8.

Afterwards, he blessed containers of water for their use in bathing and drinking. Where recommended, some women also bathed in consecrated streams for the purposes of divine healing. Babalola was said to have sanctified waterbodies, such as River Ariran in Ikeji Arakeji and River Oni in Efon-Alaaye, for use not just by expecting mothers but other ailing people.[223] River Ariran remains the most popular of these consecrated waters as it was situated in the location of Babalola's prophetic call, and was known to have assumed healing properties at the onset of the prophet's ministry. An excerpt from a CMS magazine in the 1930s reflects Babalola's practices: "His [Babalola] method of procedure at his meetings was to pray…and then to bless water brought by the people in calabashes and bottles. The water was later drunk by them to the healing, as they believed, of disease, or the making of childbirth possible."[224] Babalola held that he received divine instruction to use consecrated water for healing.[225] Once blessed, the water assumed divine power, capable of cleansing and healing. One common song among adherents during this era stated: *Omi la o mu ye Aladura*, *Omi la o mu ye* (As *Aladura*

---

223 NAI OYO PROF 662, 2; Pastor E.O.T. Olorunwa, c.85, Interview, CAC Mountain of Blessing, Odi Olowo District, Lagos, March 23, 2016.

224 CRL CMS ACC 716 F8, January 1932, 1.

225 Pastor E.O.T. Olorunwa, Interview cited.

people drink water, they will always remain alive and well).[226] Water was, thus, considered the sign of Babalola's calling and an enduring practice in *Aladura* liturgy.

At the onset of labor, expecting mothers returned to church and received assistance from prayerful female leaders and members of the church until birth occurred. Selected psalms were recited to ward off misfortune during labor. As early as the 1930s, the maternity services extended to non-Christians and non-members of *Aladura* churches. This childbirth service served a dual purpose of healthcare and evangelism. Some non-Christian attendants eventually converted to the Christian faith after months of teachings, prayers, and assistance from *Aladura* workers.[227] With time, particular fervent older women, who generally had more experience about childbirth, became responsible for matters of pregnancy and childbirth. They were identified with the name, *Iya Agbebi*, a Yoruba term for midwife. Water, oil, psalms, and prayers were their chief tools of operation.[228]

---

226 Elder Moses Adebola Olowe, c. 75, Secretary of CAC Oke-Ife, Interview, CAC Oke-Ife, November 18, 2015

227 Ibid.; Comfort Aliko, c. 81, Retired Midwife for CAC Agbowo, Interview, her residence in Agbowo, Ibadan North; Pastor E.O.T Olorunwa, Interview cited; CRL H7/B/51/3/21.

228 Ibid. Note that palm kernel oil, as described in chapter one, was believed to have soothing effects on women during labor.

Figure 17: Prophet Joseph Ayo Babalola preaching in the late 1930s. Note the containers of water. Source: thenewsnigeria.com.ng

Despite its animosity to everything associated with the traditional religion, *Aladura* churches reflected the cultural beliefs of the environment in which they sprung. Matters of health and illnesses were strongly connected to the spiritual realm. Similar to African beliefs that illnesses were a product of transgression against deities and ancestors, or the evil actions of ones' enemies, the *Aladura* attributed ailments to spiritual and human causes. Pregnancy was especially considered as a vulnerable position that exposed women to the "evil eye" of their neighbors. They were prone to attacks by

spirits, and their babies could be possessed by the *Abiku* spirit (spirit-children), and thus die soon after birth.[229] Members of the *Aladura* church believed in the existence of these spirit-children and crafted prayers to ward them off. Infants were washed in consecrated streams in order to keep *Abiku* spirits from working against them.[230] The use of water for healing can be connected to traditional Yoruba religions. Notable Yoruba deities, such as *Oshun* and *Yemoja*, had strong associations with water and could grant healing and fertility through its use.

Death during pregnancy was a crucial spiritual issue and safe delivery was claimed as the reward of good Christian women.[231] "You shall deliver like the Hebrew women" became a common utterance that was directed at expectant mothers. It was derived from the bible story in which midwives in Egypt spared the lives of male Hebrew babies, claiming that Hebrew women were more vigorous and gave birth before the midwife's arrival. This reference to birth "like the Hebrew women" remains a core part of *Aladura* beliefs.[232]

---

229 CRL H7/B/51/2/55, 3. *Abiku* is the Yoruba equivalent of Ogbanje (born-to-die children) discussed in Chapter 1. It involves children who die after birth and are reborn only to die again, a constant concern of pregnant women.

230 CRL H7/B/51/3/21, 41-42.

231 Ibid.

232 *Exodus Chapter 1 verse 19*, Holy Bible, New International Version.

The Precipitators of the *Aladura* Movement

The *Aladura* Movement emerged in Western Nigeria among the Yoruba for various reasons. Most notably, Christian missions had been present in Yoruba territories for a long time. They first became active in Abeokuta as early as 1842. The earliest mission was the Methodist Church who were soon joined by the CMS in 1843.[233] By the 1900s, grudges had accumulated against the deliberate exclusion of Africans from top positions in church hierarchy. Local converts were elevated to the posts of catechists, evangelists, and church teachers but hardly became priests and bishops nor received any other high ranking leadership post.[234] In some cases, they were not accorded full church membership.

Additionally, many converts were dissatisfied with the distance that the church created between Christianity and local culture. A number of earlier movements, such as Garrick Braide's in the Niger Delta, showed that local people were more amenable to religious movements attuned to their cultural systems. Foreign missions were considered as intolerant of indigenous social systems and moral codes, displaying utmost disregard

---

233 Peel, *Aladura*, 55

234 Bishop Ajayi Crowther was the first African bishop. After his death in 1891, there was a decision not to select an African as his successor, despite Ajayi's exceptional performance as Bishop. Africans were not considered eligible for higher posts. See Ibid.

for traditional institutions.[235] One aspect of culture that came under attack by the missionaries and also created a lot of discontent among local converts was the practice of polygamy. With a largely agrarian economy, Nigerian families were predominantly polygamous because family size determined the labor force available to households. The CMS, Methodists, and other missions showed no tolerance for polygamy and required monogamy as a prerequisite for baptism and full church membership. Converts who wished to be baptized were forced to divorce all their wives except one. This requirement unsettled many new Christians and was one of the issues that triggered separatist movements. Most of the early founders of *Aladura* churches were polygamists, and others tolerated it in their churches. The only exception to this case was Faith Tabernacle (later known as Christ Apostolic Church). [236]

Another notable event that created a viable environment for religious movements was the constant presence of plagues and epidemics in Yoruba towns since 1918 and throughout the 1920s. The influenza epidemic of 1918 had seriously affected Lagos and other surrounding towns, causing a lot of tensions in the society and creating a fertile environment for prophetic movements, apocalyptic divinations, and promises of faith-

---

235 Ibid.

236 CRL H7/B/4/2/101, *Ecumenical Review*, "On Christ Apostolic Church," 422.

healing.[237] The epidemic claimed many lives and was believed to have been imported into Lagos from Ghana by sea. From there, it spread to other parts of Western Nigeria. In Lagos alone, the epidemic killed about two percent of the population, excluding unrecorded deaths.[238] Churches were closed down to avoid the spread of the disease. Many prayer meetings emerged to fill the spiritual gaps left by the churches. Visions and prophecies were a core component of these gatherings.[239]

---

237 *Lagos Standard*, 9, 23 October, 1918; "The Recent Epidemic from an Astrological Standpoint," *Lagos Standard*, 1 January, 1919.

238 UL, *Colonial Annual Reports, No. 1030, Nigeria*, "Reports for 1918," 18. Lagos had an estimated population of 84,684 in the 1920s. See WL ANN REP WA28 NH5 N68 1922-1925.

239 *Lagos Standard*, 9, 23 October, 1918; see also Peel, *Aladura*, 62.

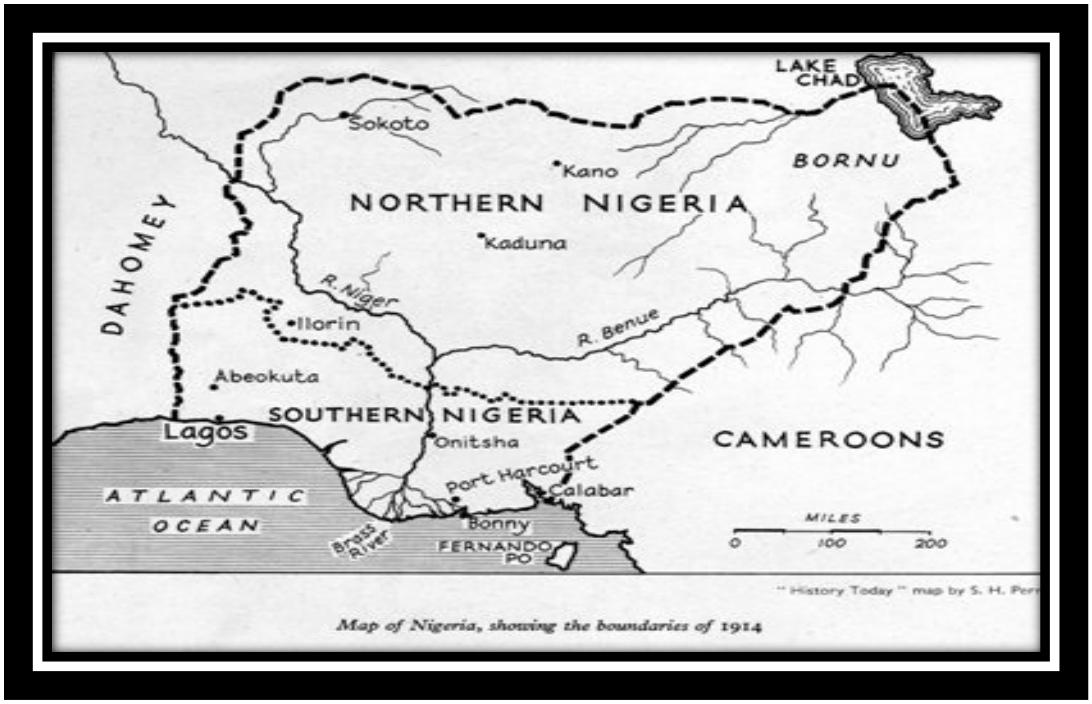

Figure 18: Map showing the position of Lagos on the Atlantic coast

Other unidentified epidemics also occurred across Western Nigeria in locations like Lagos, Ijebu-Ode, and Abeokuta between 1919 and 1924. The colonial annual report of 1925 recorded the outbreak of bubonic plague in Lagos in 1925. The disease was spread to Abeokuta by a child who had contracted it while visiting Lagos.[240] The vulnerability of this region of Nigeria to epidemics was linked to the position of Lagos as the colony's most important port city. It attracted cargoes and peoples from different

240 UL *Colonial Annual Reports, No. 1315, Nigeria,* "Reports for 1925, 12.

parts of the world, and with this traffic came all kinds of diseases.[241] Gradually, the prayer groups that emerged in response to the influenza and other epidemics matured into more permanent features in the Yoruba Christian climate, creating a suitable atmosphere for prophetic movements in which *Aladura* churches were to feature prominently.[242]

Enter the *Aladura*

One of the notable churches later classified as *Aladura* came into existence in the wake of the 1918 influenza epidemic. It was first known as the Diamond Society or Precious Stone, formed by members of St. Saviors Church, Ijebu Ode in the house of the church's Peoples Warden - J.B Sadare. The group emerged after the closure of St. Saviors Anglican Church, and continued to thrive after the epidemic. It was formally inaugurated into the Anglican Communion on July 1920. Trouble with the Anglican Church began, however, following the group's absolute reliance on dreams and visions for guidance, their belief in faith-healing, and condemnation of infant baptism.[243] The conflict between the society and the church could no longer be ignored, and in 1923,

---

241 Ibid., 10, 12.

242 CRL, *West Africa*, H7/B/7/2, 3.

243 H.W. Turner, History of an African Independent Church (Oxford: At the Clarendon Press, 1967), 9; Peel, *Aladura*, 62-63.

Sadare and other members of the group severed ties with the Anglican Church. They founded a separate church named Faith Tabernacle.

Faith Tabernacle in Nigeria was allied with a church of the same name in Philadelphia, USA. The Nigerian church especially sought this international alliance because of beliefs that government gave more tolerance to foreign rather than indigenous missions who they believed to be unpredictable and rebellious. British colonial officers saw churches with foreign affiliations as better managed and more compliant to colonial laws.[244] The British administration had, after all, experienced in other parts of Africa the challenges that such independent African churches posed.[245] To attract a favorable disposition from the colonial government, Faith Tabernacle thus established an alliance with the US church. Like its Nigerian counterpart, the church in the US laid emphasis on the effectiveness of prayer, a total reliance on faith-healing, and personal sanctity.[246] Under the umbrella of Faith Tabernacle, Philadelphia, which constantly sent pamphlets to

---

244 NAI OYO PROF 1/28, *Aladura Movement (Apostolic Church)*

245 Precedents existed in Nyasaland during John Chilembwe's religious-related uprising in 1915, William Wade Harris's religious movement in Ivory Coast in 1913, and the 1921 Kimbanguism in Belgian Congo (Congo DRC). See Linden and Linden, "John Chilembwe and the New Jerusalem." For the other movements, refer to Jenkins's, *The Next Christendom*, 46-50.

246 Peel, *Aladura*, 63-64.

Nigeria, the new church spread across Yorubaland, including among the educated class. Nonetheless, the doctrines of the two churches differed in several ways, especially in their views on prayer. Faith Tabernacle in Philadelphia emphasized the individuality of prayer, a belief that prayer was between the affected individual and God, as opposed to the prayer of intersession upheld by the Nigerian church. By 1928, relations with the US church collapsed, partly because of a crisis in the American church leadership and their failure to send missionaries to Nigeria.[247]

Around this time, another prayer movement, the Seraphim (later known as Cherubim and Seraphim), emerged among the Yoruba in 1925 during the era of the bubonic plague that ravaged Lagos between 1924 and 1926.[248] Prayer was the society's primary objective and expectations of divine healing were high. Accounts of recoveries spread in newspapers, increasing people's interests in the new church. This movement was started by Moses Orimolade, known for his praying activities in Lagos and accordingly referred to as *Baba Aladura* (Praying Man/Elder). Like Faith Tabernacle, Seraphim started as a group under the Anglican Church but later broke away to form a distinct church with its unique set of doctrines. Orimolade gained fame and popularity after he prayed for Abiodun, the daughter of a church worker, who had fallen into a trance and would not recover. After Abiodun's recovery, witnessed by a number of

---

247 Ibid., 59.

248 UL, *Colonial Annual Reports, No. 1315,* 10,12.

people, Orimolade and Abiodun founded the Seraphim Society, a group that emphasized reliance on dreams, visions, and prayers.[249] According to Peel:

> Orimolade would pray, and then tell those present any visions he had seen. Soon many other members were seeing visions, such men and women being seen and admired as *ariran*, visioners. This practice seemed to have changed very little down to the present day. All major doctrinal and ritual developments were sanctioned by visions.[250]

Prayer meetings occurred every evening and were followed by Bible classes. The society separated from the Anglican Church in 1929. As the number of adherents increased, a Praying Band (*Egbe Aladura*) was formed within the society, comprising of committed members selected through visions and prayers.[251]

During this period, Joseph Babalola entered the scene and caused a largescale movement that the colonial administration termed the *Aladura* Movement. Babalola's arrival triggered a great religious revival in the Western Region and heralded the largest mass religious movement in colonial Nigeria. His prophetic movement advanced the

---

249 Peel, *Aladura*, 71-72.

250 Ibid., 72-73.

251 Ibid., 75.

work of Faith Tabernacle and other similar churches. Babalola was born to Christian parents in 1904 in the Ilorin Province of Northern Nigeria. At the time of his prophetic call, he worked as a steam-roller driver in Ekiti, Western Nigeria. On October 1928, his roller ceased to work and he heard a voice summon him thrice with the charge to spread the gospel. This was the beginning of his preaching career. His signature practice was total reliance on divine healing and the use of "holy water."[252]

In 1930, Babalola, now known as the *Aladura*, arrived in the Yoruba town of Ilesha and attracted a large following both in the community and surrounding towns through his claim to faith-healing. Crowds trooped into Ilesha from as far as Ekiti and Ife and departed with bottles of holy water blessed by Babalola.[253] The prophet was unaffiliated with any denomination at the time that he first visited Ilesha. He was, however, prevailed upon to identify with Faith Tabernacle, whose leaders were his most ardent supporters.[254] His activities resulted in a huge increase in the membership of Faith Tabernacle. It also swelled the membership of similar churches, such as the Cherubim and Seraphim, who also believed in faith-healing. His large following reflected the social dilemma in Western Nigeria at that moment.

---

252 NAI OYO PROF 1 662, *The Faith Healer-Babalola and the Faith Tabernacle otherwise known as The Aladura Religious Movement-Operation of in Oyo Province*, 2.

253 Ibid., 2, 6, 13.

254 NAI OYO PROF 1/28, 3.

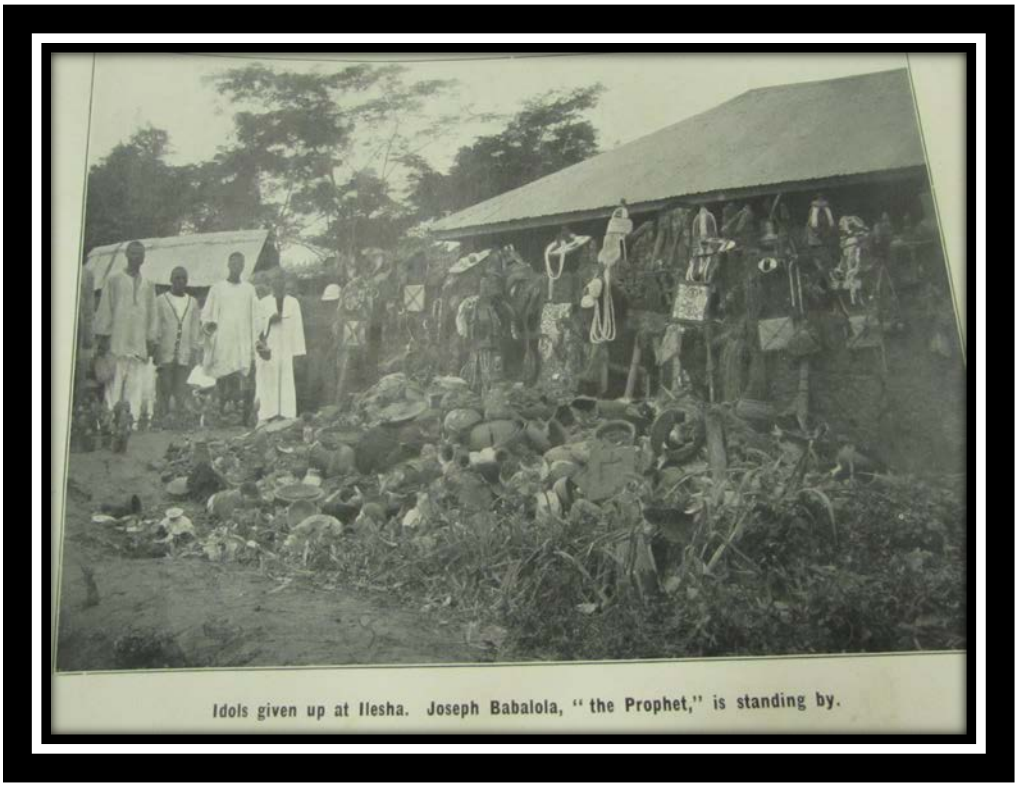

Figure 19: Idols Given Up at Ilesha. Source: CMS ACC 716 F8, 95.

As Faith Tabernacle's membership increased, its leaders sought another alliance with a foreign mission. They approached the Apostolic Church whose headquarters were in Bradford, England. The Apostolic Church sent two representatives, Pastor George Perfect and Idris John Vaughan, to examine the affairs and practices of the *Aladura* in Nigeria. After this and many other visits, Faith Tabernacle transferred its allegiance to the

Apostolic Church and changed its name accordingly.[255] This external supervision was welcomed in administrative circles as the colonial government had become concerned about the movements. The District Officer of Ife/Ilesha Division stated that, "I am prepared to believe that with adequate European supervision, this movement will be as peaceful and law-abiding as any other mission."[256] A final name-change for the church occurred in 1943 when it became free of any foreign supervision and assumed the name Christ Apostolic Church (CAC).

During Babalola's religious revivals, other prophets emerged and extended the revival into various corners of Yorubaland. Another important *Aladura* church, Church of the Lord-*Aladura*, appeared during this time. Its leader was Josiah Oshitelu, a former Anglican teacher. Like other prophets and AIC leaders, his reliance on visions and faith-healing caused a rift between him and the Anglican Church and resulted in separation. He commenced open air preaching in a small village named Ogere, and became popular in the 1930s during the course of Babalola's revival. Oshitelu had close ties with Faith Tabernacle and held similar beliefs in divine healing, the purging of idolatry, and spiritual baptism. The relationship between Oshitelu and Faith Tabernacle broke down over Oshitelu's (and his disciples') use of holy names in prayer said to have been

---

255 Ibid., 3.

256 Ibid., 5.

revealed in dreams, the fixation on exposing witches, and the toleration of polygamy.[257] Other lesser known *Aladura* churches also derived from the 1930s revival.

The structure of these *Aladura* churches reflected a syncretism of practices deriving from the older Christian missions from which they emerged. At the apex, the typical *Aladura* church had a General Superintendent and Most Rev. Prophet, followed by an Apostle, Rev. Prophet, Bishop, Archdeacon, Rev. Deacon, Prophet, Pastor, Captain and Acting Prophet, Teacher, Follower, Leader, and Cross Bearer, in that order. A notable trend that distinguished the *Aladura* administration from older missions was that male positions of authority had female equivalents. Thus, the office of the General Superintendent and Most Rev. Prophet was matched by that of the Rev. Mother while the Rev. Deacon's position had a Rev. Deaconess equivalent.[258] This practice did not, however, translate into female equality to male leaders. Some female officers could only act in certain capacities in the absence of a male officer. In some instances, especially regarding baptism, their activities were limited to the female population while such restrictions did not apply to men. Many of the churches also kept women out of the

---

257 Faith Tabernacle was the one *Aladura* church that expressly condemned polygamy probably due to its western affiliations. See Turner, *A History*, 22-24.

258 See CRL H7/B44/126, *The Rules and regulations Observances and the Constitution of the New Salem Holy Saviour's Church (Aladura),* 11-24.

sanctuary during menstruation, imitating some traditional practices of seclusion for menstruating women.

The preventive rather than curative nature of *Aladura* healing was one of the characteristics that made it appeal to a population that favored a mix of curative and preventive medicine. Colonial maternal and infant care prior to the *Aladura* era emphasized curative medicine.[259] The *Aladura* Movement, on the other hand, satisfied the desire by the local people to enhance their fertility and safety throughout the duration of pregnancy and during childbirth. Families sought protection from the various physical and spiritual forces that could undermine their wellbeing. By offering preventive healing services, albeit spiritual in nature, the *Aladura* alarmed western doctors and nurses because of the rates in which people left hospitals for the *Aladura* revival sites.

Faith Healing among the *Aladura*: Nature and Responses

The religious movement that Babalola triggered had no tolerance for any type of medicine. Traditional medicine was associated with idolatry and witchcraft, two themes that were common in the 1920s in missionary and colonial circles. Babalola and his followers believed that herbs were prepared with incantations, and even when they were not, they were inherently associated with the traditional religion. Recourse to

---

259 Rockefeller Archive Center (RAC) FF R2756 081500620000, *Ford Foundation Grant File*, PA 815-62, 3.

biomedicine was considered as a lack of faith in God. In Faith Tabernacle (CAC), the denomination that Babalola allied with, absolute reliance on God and prayers was required of the true believer.

The preponderance of faith-healing from the late 1920s in many Yoruba provinces became a source of concern to the colonial administration as a result of the health risks that it posed. Sick people flocked to the churches and revival venues for prayers and healing, at times congregating in the venues for extended periods. This was a major issue for the colonial government as they saw it as a public health hazard. The reason for such concerns was that communicable diseases could easily spread in such public gatherings. Unhygienic conditions as well as the simultaneous use of water sources, such as streams, by the ill and healthy also promoted the thriving of diseases. People from across the Western Region thronged to Babalola's revival meetings, "clerks as well as bushmen; Mahammedans [sic] and pagans as well as Christians."[260] The greatest attraction for people was Babalola's possession of healing abilities. A colonial agent summarized the traffic that ensued during revival and prayer meetings thus:

> Recently I have been spending much time in road work on the Ijebu-Ijesha road and I have been very struck by the extraordinary numbers of people, mostly women, who are pouring into Ilesha…. It is the same on the other

---

260 NAI OYO PROF 662, 2.

> roads, and the market is check-a-block with lorries which have brought passengers in from a distance.[261]

In addition to the health endangerment that could result from the congregation of sick people from different towns, colonial officers feared that religious movements of this magnitude could pose a risk to established authority. Not only was the new religious movement and the growing Faith Tabernacle placed under scrutiny, deliberate efforts were made to sabotage their efforts. Local chiefs, notably the Owa, were instructed to discourage efforts by Faith Tabernacle to establish churches in their territories. Orders were obtained to stop the church from using church structures constructed for worship while officers suggested that they be denied leases.[262] According to one such colonial officer:

> A second object of my visit to ESA-OKE, and of my subsequent movements, was propaganda against 'faith-healers' and 'prophets'. The ESA chiefs have forbidden the small church which has been erected to be used until official sanction has been obtained through the Owa…. I also advised the Chiefs not to show them any encouragement as it was not a

---

261 Ibid., 2.

262 Ibid., 12-13.

> movement which could benefit the town…. Some of them [church members] were very chagrined at the number of persons I induced to laugh at them…. [I] did all I could to ridicule the movement.[263]

Senior Resident of the Oyo Province routinely instigated chiefs to bully members of the *Aladura* movement, especially Faith Tabernacle, Church of the Lord-*Aladura*, and Cherubim and Seraphim. They were presented as threats to the Chiefs' authority and as the Oba's enemy; a source of destabilization and conflict in the towns.[264]

The activities of certain followers of Babalola and other prophets of the *Aladura* Movement brought the prophet under more government scrutiny. One such follower, Abigail, instigated converts in Ilorin and Akure in the 1930s to desist from paying taxes to the government. Around the same time, Oshitelu, founder of Church of the Lord-*Aladura*, began some anti-government teaching and prophecies contained in a pamphlet called *Awon Asotele* (book of prophecies). Babalola opposed these outright political confrontations and embarked on tours to counteract and distance himself from Oshitelu's sermons. Babalola once came under the investigation of the Resident but was found to

---

263 Ibid., "Extract from memorandum NO. 404/30/1930 of 20th April, 1931, from A.D.O. Ileshato District Officer, Ife," 13.

264 NAI OYO PROF 662, 22-23; NAI OYO PROF 662, 31-38, 46.

pose no direct threat to the government. The Commissioner of Police for the Ondo/Oyo Province recorded that Babalola opposed anti-government teachings.[265]

Though Babalola's religious movement did not assume any obvious political dimensions, it represented a massive subversion of a larger scale than any political confrontation. A sizeable portion of the local population, for the first time since the advent of colonialism, assumed control over their physical and spiritual needs. Though it refrained from challenging political authority, the *Aladura* Movement affected other aspects of colonial rule, notably colonial missionary establishments and medical institutions. As shown in Chapter 3, medicine was a key component of colonial advancement. The harbingers of biomedicine - missionaries - used the Christian religion to make the local population more subservient to colonial rule. Religion and medical care were, thus, the main propaganda tools for buttressing colonial conquest and rule. By its existence as a movement both distinct from western Christian missions and opposed to the use of biomedicine, *Aladura* churches removed apart of Western Nigeria's population from the control of colonial and missionary agents. They emptied hospitals and created a local group that was mostly independent of some instruments of state control, hence the government's discomfort about their activities.

Older missions such as the CMS and the Wesleyan missions felt threatened by this growing sect as many of their followers were attracted to the promise of healing and

---

[265] Ibid.

the fact that the new religious group was "a free one," unlike the major missions who had to be supported financially by the locals.[266] Evidence from a CMS report showed, nonetheless, that the mission admired and in fact appreciated Babalola's work as it brought a lot of inquirers and new converts seeking knowledge and better relationship with God to CMS churches. According to the report:

> It is an inspiring sight to see up to three hundred people of all ages, from eighteen to sixty years, coming once or twice a day, every day of the week, to class, and to see the devotion of ten to thirty helpers attending regularly. What better evidence of zeal to know that the Lord could be desired? The inquirers have learned quickly, and hundreds have already been baptized.[267]

Skepticism existed in several quarters among the CMS, however, especially after Babalola broke ties with the CMS and decided to become a part of the Apostolic Church

---

266 NAI OYO PROF 662, 9.

267 CMS ACC 716 F8, *The Church Missionary Outlook*, Vol. LIX, January 1932, 2; CMS ACC 716 F8, *The Church Missionary Outlook*, Vol. LIX, January 1932, September 1932, 183.

(CAC).[268] At this point, the CMS secretary issued a pastoral letter across the diocese barring its members from participating in *Aladura* activities.[269] Despite these oppositions, the *Aladura* Movement thrived.

Outside general church and revival meetings, sick people received direct spiritual attention inside the church. Officiating persons first sought spiritual guidance regarding appropriate approaches to be adopted in achieving healing for the sick. Though practices differed between Faith Tabernacle and Church of the Lord-*Aladura*, the major principles were similar and derived from the bible. Approaches to spiritual healing generally included nine methods:

1. By faith command.
2. By breath of virtue.
3. By attendance of holy disciples.
4. By the use of handkerchiefs and aprons.
5. By means of anointing.
6. By consecrated baths and holy washings.
7. By auto suggestions, affirmations, and virtues or the use of words of power.

---

268 Ibid., 2-3.

269 CRL CMS ACC 716 F8, September 1932, 183.

8. By the laying on of hands on the sick.
9. By the use of visible material objects such as salt and healing water.[270]

Specific prayers were also created by various *Aladura* sects to address particular conditions and ailments.[271] Such was the organization of faith-healing in the pre-independence era.

The Communion of Women: Faith Homes and the Work of Midwifery

The transition from an informal maternal birthing space to a professional class of religious midwives came to its peak in 1959, however, efforts towards a more organized structure began in the 1940s. Since church positions were distributed on a gendered basis, a framework for the care of pregnant women emerged in the 1940s in which lower ranked female officers, such as the Lady Leader, doubled as midwives and assisted women during pregnancy and labor. Other leaders, such as the Prophetess and Lady Evangelist,

---

[270] CRL H7/B/51/2/54, "An Address Entitled 'Facts about Faith, Psychic, or Spiritual Healing,' delivered by Dr. E.O.A. Adejobi, the Primate of Church of the Lord (Aladura)," 13-14.

[271] See Ibid., 12, 14-15; CRL H7/B/51/2/55 (1932).

catered for the sick and could therefore assist expecting mothers too.[272] In some churches like the Church of the Lord, praying groups like The Ladies Praying Union were formed and charged with the responsibility of praying for the sick and attending to pregnant women.[273] Those who had severe or more pronounced cases were encouraged to remain in church for a number of days while prayer bands and prophets/prophetesses worked to provide them respite.[274]

In 1959, however, Babalola founded a Faith Home in Talafia, Ede, Osun State shortly before his death. The Faith Home became a center of spiritual empowerment as well as a space for the sick to receive spiritual aid for their ailments. It was, nevertheless, mostly dedicated to the care of pregnant woman. Babalola believed that he received a spiritual mandate to establish such an institution for expectant mothers.[275] As observed earlier, women formed the bulk of Babalola's followership, hence the strategic importance of his introduction of a Faith Home to the church organization. The location became a major center of prayer and divine healing for CAC as well as other *Aladura*

---

[272] Evidence of this arrangement is seen in the Constitution of The New Salem Holy Savior's Church (Aladura), founded in 1946. See CRL H7/B/44/1/26, 24.

[273] See CRL H7/B/51/1/96, *The Ladies Praying Union, Its Rules and Regulations*, 3.

[274] Interview with Elder Moses Adebola Olowe; CRL H7/B/51/3/21, *Nigeria*, 40.

[275] Midwife Oluwaleye Ara, c.56, Interview, CAC Mountain of Blessing, Odi Olowo District, Lagos, March 22, 2016; Pastor E.O.T. Olorunwa, Interview cited.

churches. No use of traditional or biomedicine was allowed and there was total reliance on prayers. In recognition of the Home's core responsibility, its maternity wing was named CAC Good Women's Hall.

The organization from which the Faith Home's maternity center derived its name came into being in 1944 as CAC Good Women Association. By 1959, it was a strong propaganda arm of the church. Its aim was to shift women's roles in the church from that of mothers and wives to more active participants in church development. Having placed themselves outside of foreign missionary control and government propaganda, the Good Women Association provided their versions of appropriate Christian and secular teachings to church members, ranging from designing secular academic curriculum for the church's female population to organizing healthcare delivery for women and children. They also arranged zonal and annual conferences in which lectures were provided on security, evangelism, revival, and health talks. Their annual reports, which contained recommendations for church development, were submitted to the church's general council for consideration and possible adoption. From the time of its formation in the 1940s, the organization played a central role in the provision of care to pregnant women. The group was central to the inauguration of the maternity center at Ede in 1959, providing its key personnel - the matron - and turning the center into a blooming

midwifery training center that remains popular among all *Aladura* and other Pentecostal churches.[276]

Figure 20: The old Faith Home built in 1959 by Prophet Babalola

The structural organization of healthcare that occurred in Ede was targeted at providing a coordinated faith-based medical care for CAC adherents in order to prevent the harassments that the church suffered from medical institutions and the government for their reliance on faith-healing. What Babalola and the CAC Good Women Association orchestrated in 1959 resulted in an enduring institutionalization of Faith Homes within CAC and other *Aladura* churches. Their initiatives led to an organized system of faith-

---

276 Midwife Oluwaleye Ara, Interview cited; Pastor E.O.T Olorunwa, Interview cited; H7/B/51/3/21

based maternity care and training across CAC churches. It also resulted in the emergence of independent religious institutions whose goal was to provide faith-based maternity services for women.

Figure 21: Signpost for a Faith Delivery Home, Ibadan

Ede became a training center for all midwives associated with CAC, leading to the rise of a specific class of career midwives. Other *Aladura* churches imitated this structure and sent their midwives for training in the Faith Home. The midwives received a one to two-year training in Ede after which they were posted to their various churches and occasionally transferred to other locations after a period of service. The training was both practical and spiritual, with emphasis on prayers and spiritual sensitivity. An annual

conference was instituted in which midwives took refresher courses.[277] A look at one of the pamphlets for these conferences showed that midwives received instructions on causes and prevention of maternal deaths, and risks in the first twenty-four weeks of pregnancy. They also embarked on marathon prayers to equip them for handling spiritual cases that deterred successful births. The Lady Evangelist, a notably spiritual leader, was appointed as Matron-in-Charge of the Faith Home. She was required to have years of experience in matters of childbirth, an easy requirement to fulfill as Lady Evangelists were assigned the care of expecting mothers earlier in *Aladura* history.

Figure 22: Revival/Conference Center at Ede

---

277 Midwife Oluwaleye Ara, Interview cited; Pastor E.O.T Olorunwa, Interview cited; H7/B/51/3/21.

Since the Home's formation in 1959, *Aladura* churches, notably CAC, designated specific spaces for delivery in their church branches across the country. The names of these birthing centers varied from Faith Home to Faith Delivery Home and Faith Maternity Center. Those who desired to deliver their babies in the church facility were required to register with the church midwife between 3 to 5 months of pregnancy. Women ran the risk of rejection if they failed to adhere to this rule. The requirement was to ensure that the women received regular spiritual attention through constant prayer. They attended a two-hour prayer session once weekly. [278] These prayers addressed every possible spiritual issue that could be anticipated or had been foreseen through prophecy. After the meetings, the women left with bottles of water blessed by the midwife.[279] In some instances, the church pastor was invited at the end of these meetings to pray for the expectant mothers. The midwives also dealt with issues of barrenness or infertility, believed to be caused by unfavorable spiritual forces or one's enemies.[280]

---

278 Ibid., Interview with Comfort Aliko.

279 Interview with Midwife Oluwaleye Ara; Interview with Elder Moses Adebola Olowe; CRL H7/B/51/3/21, *Nigeria*, 40.

280 CRL H7/B/51/2/55, 5.

Figure 23: Upgraded delivery home at Ede

Figure 24: Contemporary Maternity Center at an *Aladura* church in Ibadan

Figure 25: Maternity ward in the same Ibadan church

Figure 26: Labor Ward at the Maternity Center

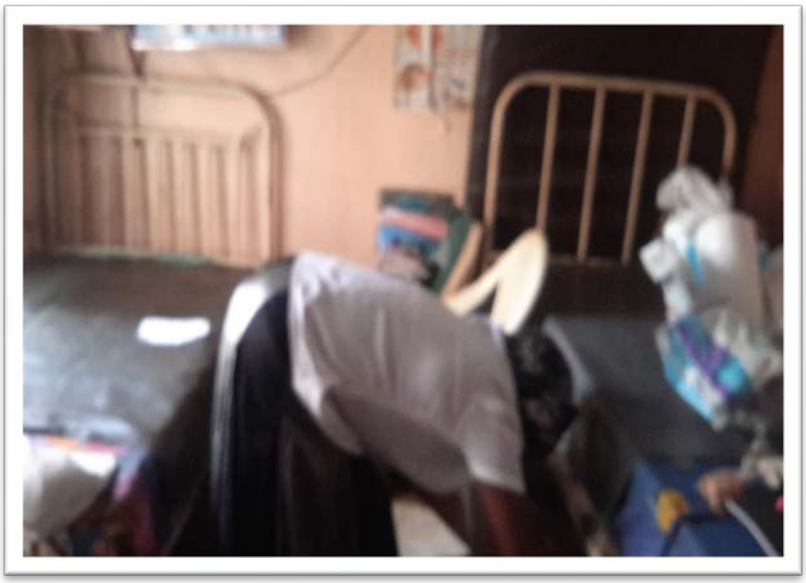

Figure 27: Faith Home, CAC Mountain of Blessing, Odi Olowo District, Lagos

Like their local counterparts in the villages, most career *Aladura* midwives indicated that they received a divine call to midwifery through dreams.[281] Some midwives reported that they got precise instructions in these dreams on how to assist pregnant women or attend to specific cases. At the end of these revelations, they began helping church members during childbirth. They eventually enrolled in the Faith Home at Ede for training. Churches also selected women to receive midwifery training in Ede. In

281 Interview with Comfort Aliko; Interview with Moses Adebola; Interview with Pastor E.O.T Olorunwa; Interview with Midwife Oluwaleye Ara.

this case, such women returned to serve their church for a period before transfer to a different location.[282] These midwives made the endurance of faith delivery homes in Nigeria's medical and religious landscape possible.

Conclusion

Faith delivery homes served a significant population in Western Nigeria, especially because they were a cheaper alternative to hospital births. They took care of the spiritual, physical, and psychological aspects of childbirth, and like their older competitor, the missionary maternity, they also became an instrument of evangelism and indoctrination. By 1960, they were a permanent feature of Nigeria's reproductive and religious scene.

The provision of women's healthcare by African Independent Churches was a result of the social circumstances of the period. In the late 1920s, foreign Christian missions could barely meet the medical needs in their territories. Missions, such as the CMS, had few medical missionaries available to replace the local doctors that they discredited. This period coincided with waves of epidemics, from the Bubonic plague in 1918 to the Influenza epidemic of 1928, and other small pox outbreaks in Western Nigeria. High infant mortality rates also prevailed, pushing women to embrace any promises of fertility. The appearance of Babalola and his promise of divine healing,

---

282 Ibid.

therefore, found fertile ground. Women thronged to his meetings due to the desire to reproduce and the fear of malignant spiritual forces. This high female membership influenced the establishment of a faith-based delivery home, manned by trained midwives. This religious birthing space has since evolved in its practices and remains a significant instrument of evangelism and conversion among AICs. The desire to "deliver like the Hebrew women" has remained alive. Nonetheless, these faith clinics became part of a hybrid birthing culture that developed in the colony of Nigeria. From their inception in the 1930s until Nigeria's independence in 1960, they, like other maternity institutions, underwent a series of adjustments to their practices in response to the political and social circumstances of the time.

Chapter Five

When the Music Changes: The Blending Together of Three Birthing Traditions

Introduction

On the road to a series of towns in the central part of Anambra State stood a signboard that read "Native Maternity Center."[283] The two keywords on this sign - native and maternity -attracted my attention and raised questions about the period when this post was put up as well as the people it catered to. The word, "native," was not a coinage from the twenty-first century, an era when its use was considered derogatory and hardly applied. The vocabulary belonged to the previous century and signified the local or the "other" during the colonial era. Up to the 1930s, missionaries and colonial officers used it to describe local women who trained as midwives. Local medical practitioners adopted it eventually to signify their practices.

---

283 This Signboard was located specifically at a junction in Obeledu. In 2017, I requested a photograph of it through a contact in one of the communities but learned that it had recently been removed to make way for road construction.

"Native" and "Maternity" also represented two different kinds of birthing cultures. While one marked the "traditional," the other was colonial and western. Additionally, traditional birthing institutions were not marked by signposts, permanent structures, and designated centers. Traditional midwives tended to expecting mother in the mother's marital or natal home. Native Maternity Center was, thus, a name that indicated a shift in the birthing status quo. Such shifts were common for most of the colonial period. This chapter explores the hybrid remodeling of traditional, colonial, and religious birthing institutions to ensure their continued relevance. Private practices, involving biomedical and traditional midwives, characterized this period. Traditional midwives attempted to professionalize in order to compete with the changing colonial climate while colonial maternities took measures to dominate the reproductive landscape. The birthing facility indicated in the signboard belonged to a midwife and represented some of the changes that traditional midwifery underwent in the colonial era.

Hybrid Cultures: The Development of Private Birthing Homes

As the location of childbirth in Nigeria shifted to hospitals, especially from the 1930s, changing interpretations of proper birth compelled traditional midwives to construct physical structures that catered to pregnancy and other gynecological ailments. The same phenomenon occurred within faith-healing organizations. This trend emerged at a time when western education and urbanization had changed cultural approaches to childbirth. The emergence of private birthing homes was one of the results of these

developments. They began not with traditional midwives, however, but with their hospital-trained counterparts.

An early complaint of missionaries regarding the training of women for midwifery work was that they tended to marry and abandon their work post. From the 1930s, however, these corps of married midwives charted a new course for themselves. To fill the healthcare void that existed in many communities as late as 1959, trained midwives constructed permanent structures that served as maternity homes, opening new economic opportunities for themselves. This development coincided with the period when government intervened more in maternal and child welfare. Therefore, the private facilities constructed by midwives were subjected to government regulations. A typical birthing home comprised of four beds, the government-recommended number per midwife in mission hospitals.[284] Some midwives built larger maternity homes and employed other midwives, triggering another new trend in the field.

As private birthing homes expanded, an apprenticeship system emerged in which traditional midwives attached themselves to trained midwives in order to learn and combine important components of biomedical birthing methods in their own practices. Midwives who completed apprenticeships with their hospital-trained counterparts established their own birthing homes and adopted beds in place of traditional birthing

---

284 Cadbury Research Library (CRL) CMS ACC 165 F27, *The Private Owned Maternity*, 1-3.

postures. Conditions in many urban and rural areas no longer permitted for birthing in open backyards, as previously practiced. Developments in the society prompted this relationship between trained and traditional midwives. During the confrontation between traditional culture and forces of westernization, individuals and communities created a synthesis of the two worldviews. A product of this synthesis, with regards to medicine, was the coopting of tablets and syringes as a symbol of health. In the traditional setting, certain objects or elements, such as water, medicine, or other charms and talisman, symbolized healing. In the colonial medical landscape, injections and tablets became the new symbol of healing, such that missionaries observed that people flocked to the hospitals and dispensaries for tablets and would not leave without them. To the locals, tablets and syringes conveyed the magic of western medicine.[285] It became expedient for traditional midwives to adopt these fusions in their practice.

Also, western education was a core part of Christianization and western civilization, and with it came the creation of an elite who looked down on traditional lifestyle. Local practices, therefore, lost their popularity in areas that embraced western education. Western forms of medical care represented the status of this western educated class. Since education up to the 1930s was largely controlled by missions, the first generation of educated elites were often always Christian, and because of the negative

---

285 CRL, *Medical Missions Quarterly, Nos IX to XVI,* London: Church Missionary Society, Salisbury Square, E.C., 88.

missionary attitude to local cultural practices, mostly held local customs in disdain. In missionary circle, traditional midwifery as well as herbal practices were associated with paganism. As a result, many Christians in Nigeria desisted from associations with them. Midwifery became not only a matter of faith but of class and prestige. Those who subscribed to the "old" ways were looked down upon as underprivileged and inferior while many educated families preferred hospital birth or delivery in other facilities run by trained midwives.[286] Among communities that rejected missionary education and western lifestyle until the late colonial period, traditional medicine held sway. Such communities included the Udi, Nkwelle, and Ezza Igbo, and many Northern Nigeria communities where British policies slowed westernization.[287]

Missionary propaganda against midwives helped to mold the attitudes towards traditional midwives, especially among urban dwellers and the educated class. Propaganda activities included puppet shows, where trained nurses and midwives displayed the dangers of traditional midwifery and made caricatures of the midwife.

---

286 E.A. Ayandele discusses some of the effects of mission education on Nigeria. See E.A. Ayandele, *The Missionary Impact on Modern Nigeria 1842-1914: A Political and Social Analysis* (London: Longman Group LTD, 1966).

287 Elizabeth Isichie, *A History of the Igbo People* (London: Macmillan Press, LTD, 1976), 192. Chapter 3 discusses in detail British policies regarding missionary activities in Northern Nigeria.

Nurses replicated hospital settings in a pristine way while traditional midwifery was represented in an unclean and unorganized manner.[288] These health performances were commonplace by the 1950s.

Figure 28: Puppet Show depicting old and new midwifery[289]

288 RCSL Y3043TT, *The Weston Collection*, "Nursing in West Africa Slides, 135-285."

289 RCSL W3043UU, The *Weston Collection*, "Nursing in West Africa Slides, 1-226."

Figure 29: Depiction of Hospital Midwifery during a Health Week performance[290]

290 RCSL Y3043TT, *The Weston Collection*, "Nursing in West Africa Slides, 135-285.

Figure 30: Depicting Traditional Midwifery as "Dangerous Midwifery" during the same Health Week as above[291]

291 Ibid.

Figure 31: Health Week: Traditional Midwifery represented[292]

Felicia, a midwife, was a product of this new cultural synthesis that began in the first half of the twentieth century. Despite her formal training, she was adept in the use of herbs, and employed traditional and biomedical therapies for pregnant women. In the earlier stages of pregnancy, she applied biomedical medications. Between the fourth and eighth month, however, she administered local roots and herbs which she picked out biweekly from the forests of a neighboring town. She gained her knowledge of indigenous medicine from her mother, a traditional midwife, who practiced between the 1940s and 1980s. She served as her mother's apprentice, a natural successor to her position. With the entrenchment of colonialism and the consequent discrediting of

---

292 Ibid.

midwives, however, Felicia was sent to a midwifery training center to acquire knowledge about hospital births. In this way, she created a practice that combined traditional and western knowledge.[293]

Prominent and very skilled midwives participated in this fusion in an empowering way. The 1950s and the period leading to independence created an environment in which indigenous ways of life was being revisited. This climate encouraged the desire among midwifery students to obtain knowledge of and incorporate local practices during childbirth. Therefore, they sought out renowned traditional midwives from whom they obtained instructions on indigenous approaches to childbirth. These midwives recognized the economic incentive that this prospect produced, and midwives like Mary Ugwuanyi charged for providing this service.[294] The preponderance of this practice was displayed in the constant misunderstanding between me and my elderly interviewees, who continually thought I was training to be a midwife and was, thus, interviewing them to learn the local birthing methods. The constant admonition from them was to be courageous and selfless, and to put maternal and child welfare before material gains. One of such encounters was with Onyeugwu, whose passion for her practice still reflected during our conversations.

---

[293] Felicia Eze, c.65, Interview, Orloto, April 2, 2013

[294] Mary Ugwuanyi, c.89, Obollo Road, Nsukka, June 26, 2013.

Her oldest son, who was present during these interviews, remarked that she still acted as a midwife when summoned, despite her advanced age.[295]

Some of the midwives were especially protective of their practices, however. Chizoba, whose name resounded across her community and in rural health centers for her skills and her knowledge of herbs, recounted her invitation to Bishop Shanahan Hospital, a Catholic hospital that was established in the 1930s. She was required to apply her skills to a difficult delivery. After a successful session, Chizoba was asked to bring her herbs to the hospital, to which she refused. When asked to sign a paper, she declined and explained her circumstances at the time:

> I am uneducated; I cannot even spell my name. How do I know what they are asking me to sign? They are not looking to protect me. I must protect myself. That place is for educated people. I did not have anybody to look out for my interest. I help them with some cases, but I refuse to deal with them or sign any paper for them. There are people who are jealous of my success and have accused me of different abuses.[296]

---

295 At the time of my interview with Onyeugwu Ogwo on April 6, 2016, she was 102 years old.

296 Chizoba, c.78, Interview, New Anglican Road, Oba, Road, Nsukka, April 9, 2016.

Trado-Medical hospitals also emerged during this period, mimicking the apprenticeship system that traditional midwives adopted. Traditional medical practitioners or those who desired to train as herbalists, doctors, midwives, and gynecologists apprenticed with renowned traditional doctors from whom they learned local medical crafts. The newly trained doctors then established trado-medical hospitals where they practiced a combination of traditional and biomedical therapeutics. Nurses and nursing students staffed these facilities in order to ensure the adept use of the two therapeutic forms. Abimbola Hospital in Ibadan represented a byproduct of this practice. In the late 1980s, Dr. Abimbola opened a trado-medical hospital that catered to general ailments but was notable for childbirth and other gynecological ailments. He prided himself in handling complicated births, ectopic pregnancies, fertility issues, and fibroid during pregnancy. Abimbola's trainer was an old and popular traditional doctor from an area in contemporary Ogun State.[297] He was no midwife but knowledgeable in the treatment of gynecological ailments, a knowledge that he passed down to Abimbola.

---

297 Interview with Ademola Saheed on behalf of Duratola Abimbola, Abimbola Hospital, Ibadan, November 15, 2015.

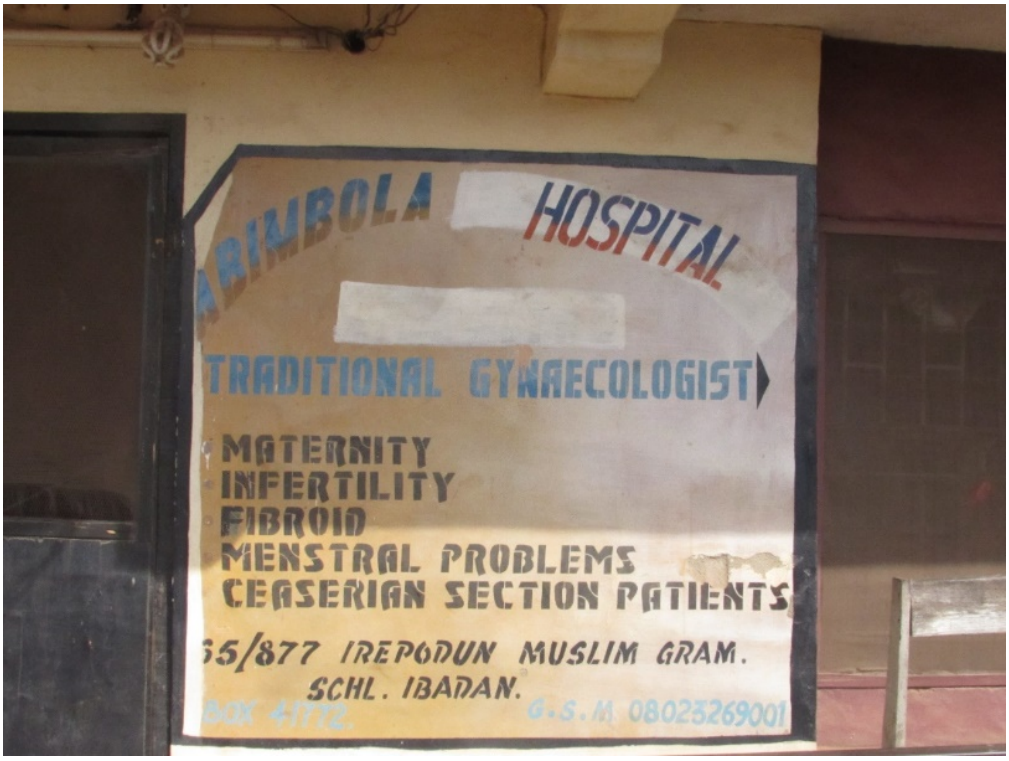

Figure 32: Example of Trado-Medical Hospital, Ibadan

The presence of competing birthing traditions also spurred attempts to professionalize traditional medicine, including midwifery, encouraging the thriving of hospitals like Abimbola Hospital. Traditional practitioners were habitually suspect by colonial agents. They were subject to arrest in the event of patients' deaths, and their herbs confiscated. To improve their lot, traditional medical societies emerged in various parts of the country to provide some organization for traditional practitioners. These organizations had specific laws and conferred membership on those whose skills had

been ascertained by older members.[298] Mary Ugwuanyi recounted her membership in the national body - National Union of Medical Herbal Practitioners - and why she joined. The organization's certificate provided her some degree of legitimacy and protected her from police harassment. Some regional organizations had rules regarding medical practices surrounding women and maternities. The Yoruba Native Doctors of the House of Shangodeyi required traditional medical practitioners dealing with difficult deliveries to summon other practitioners or face expulsion from the group.[299] Maiyedum Otu Dibia, founded in Onitsha in 1938, had similar rules. In addition, the latter group imposed fines on practitioners who failed to assist other doctors, herbalists, and midwives in need.[300] These associations created support groups and passed down their medical knowledge to selected trainees. They sustained the attempts made by traditional midwives to survive the challenges posed by colonialism and the emergence of biomedical maternities.

The insufficient nature of colonial medical service encouraged the growth of the various hybrid institutions set up by midwives and traditional doctors. Government's initial approach to the challenges of inadequate maternities and midwives was the conversion of dispensaries into health centers. These centers provided prenatal and

---

298 NAI OYOPROF 105/1921, *Native Herbal Medicine Dealers: Practice and Sale of Herbal Preparations*, 31.

299 Ibid., 25

300 NAE MINHEALTH 30/1/243, "Native Medicine," 14.

postnatal care to women. However, in many cases, they had no maternity wards, and women delivered at home. Families that could not afford the rising prices of hospital birth retained the services of traditional midwives or a relative whose services were repaid with gifts or minimal monetary payment.[301] In the 1950s in Udi Division, known for their late embrace of western ideas, an increasing number of women attended prenatal clinics to receive biomedical attention, vitamins, and other clinical examinations around the 1950s. However, they still retained their midwife's services for the deliveries.[302] Such examples existed in other parts of the country. Despite the colonial government's ten-year development plan in 1946, it could not establish more maternities due to shortage of trained midwives and the overstretching of man power, materials, and equipment in the administration's Works Department.[303] Hospitals and maternities that were considerably qualified enough to meet the requirements for training centers were concentrated in the urban towns. The standards set for them were not extended to facilities in the rural communities, thus, widening the gap between medical care in the rural and urban areas.[304]

---

301 NAE MINHEALTH 30/1/253, 127.

302 Ibid., 235.

303 NAE MINHEALTH 30/1/253, "Co-operation with Voluntary Bodies," 28.

304 Ibid., "Account of the Visit by His Excellency the Governor to Awgu on Saturday the 5th of October, 1946," 123-127

Statistics from a 1958 annual health report displayed the preponderance of private maternity centers and their popularity among locals. At this time, there was a total of 22 government maternity centers, 221 local government centers, and 64 private maternities. These centers had a total of 65,404; 36,016; and 41,773 attendance, respectively. In Ibadan Division, which had the highest number of attendance, the turnouts at private maternities was 15,782 compared to 28,496 at the government centers.[305] These statistics signify the popularity of private birthing facilities and their roles in fusing local belief systems into the hospital setting. It is also important to note that the local government hospitals, which outnumbered government and private practices, were instituted and mostly funded by local communities and, therefore, were easily amenable to local desires.

Colonial Maternity's Adjustments to Non-Biomedical Birthing Institutions

Colonial government's initial approach to the challenges of inadequate biomedical maternities and midwives was the conversion of dispensaries into health centers in rural communities. These health centers provided prenatal and postnatal care to women. However, in many cases, they had no maternity wards, and women delivered at

---

305 WL AC 149, *Annual Report of the Ministry of Health and Social Welfare*, 1958, 20-21.

home. To address these weaknesses –the shortage of staff and the sparse number of maternities – a new kind of midwife was introduced. This was the community nurse, whose services closely reflected that of the traditional midwife.

The community nurse was firstly a Grade II midwife who was then given further training in nursing and other aspects of health education. The training lasted for a year and half, and was divided into two parts. The first involved a six-month refresher course on general nursing and midwifery. The second section was a one-year training on public health, with emphasis on "domiciliary midwifery, home visiting, and child welfare."[306] At the end of the training, candidates wrote examinations conducted by the Nursing Council. Preferences for candidate selection were given to local governments with health centers or plans to establish one.[307]

Since community nurses served as domiciliary midwives who visited homes to administer their services, local governments took interest in acquiring one for their jurisdiction. Throughout the 1950s, they offered sponsorship to candidates who applied for such training. In some instances, they wrote to Grade II midwives, expressing interests in sponsoring them for community nurse training. Such sponsorship covered the midwife's salary, tuition, allowance, board, and lodging through the duration of the training. In return, the selected midwives signed bonds with the sponsoring towns stating

---

306 Ibid., E.1.4.193A/400.

307 Ibid.

that they would serve the community for five years at the end of their training. Failure to honor this agreement resulted in the midwife's reimbursement of the money spent by the local government on the training.[308] In Lagos, domiciliary midwifery was set up by the Lagos Town Council and served a large proportion of the population.[309]

Community nurses organized the maternal and child welfare services of health centers, and aided the supervision of other Grade II midwives in the area. According to Dr. E. M. Foulton regarding the community nurse:

> [The community nurse] is trained to help the mothers in child birth, to cut and dress the umbilical cord of the new-born and to advice on the upbringing of children. She can become the best friend of everybody, always welcomed and greeted wherever she goes."[310]

Their relationship with the community and the mothers, where it worked effectively, was close.

---

308 Ibid., 85.

309 BNA DV 12/68, *Nigeria: Lagos Island Maternity Hospital*, 1959, 3.

310 NAE MINHEALTH 30/1/253, "The Future of the Community Nurse in an Independent Nigeria."

Community nurses held Child Welfare Clinics where they advised mothers on appropriate childcare practices. They also organized demonstrations on the mixing of infant formulas and other food substitutes.[311] Hygiene was one of their main focus too. They visited homes momentarily, and where pregnant women could not come to the clinic during labor and childbirth, they readily conducted deliveries in the women's homes.[312] Though a community nurse in Nsukka Division reported that many mothers still delivered at home under the care of traditional midwives, they attended the child welfare clinics in greater numbers. Between January and September 1960, the community nurse in Nanka, Awka Division, recorded 1,049 ante-natal visits, and attended to 1,914 children in the centers. Fifty-seven deliveries were recorded during this period. Home-based services were as follows: prenatal care – 35, deliveries – Nil, and treated children – 469.[313] In the same period, the nurse at Nsukka health center recorded 390 attendances at the prenatal clinic, of which 87 were new participants. Out of 539 attendees to the Child Welfare Clinic, 133 were new.[314] Thus, the impact of community nurses was being felt and attendance to clinics gradually increased.[315] In Lagos, the number of supervised

---

311 Ibid., 216.

312 Ibid., "Community Nursing Report by Patricia Eze."

313 Ibid., "A Bulletin for Community Nurses in Eastern Nigeria," 6.

314 Ibid., 8.

315 Ibid.

domiciliary births was 883 in 1958 as opposed to 615 in the previous year. Home visits by midwives also expanded.[316]

As more Nigerian women manned local hospitals and maternity centers throughout the 1940s and 1950s, they increasingly accommodated local beliefs within the hospital setting, laying foundations that have persisted. Medical institutions during this time were increasingly Nigerian in nature. For instance, out of the 51 nurses, health sisters, and superintendents in the Federal Medical Service, Lagos in 1958, 96.1 percent were Nigerians.[317] Around this time also, the Federal Ministry of Health increased the already expanding number of trained Nigerian registered nurses.[318] In private hospitals, especially, the disposal of the placenta and umbilical cords followed local rules. Families received children's cords for proper burial in the babies' natal homes. Male circumcision, which was common among some communities, was inserted into the obstetric practice and occurred according to traditional requirements. In the case of the Igbo, it was performed on the eight day after a child's birth, in accordance with local customs.

The system of care for ailing family members also penetrated into the hospital setting. Historically, local women preferred birthing in their own environment. These

---

316 Wellcome Library (WL) H1B 948, *Annual Report of the Federal Medical Service*, 1958, 33-34.

317 Ibid., 3-4.

318 Ibid.

settings were often recreated in health facilities, allowing hospitalized women to be attended by family members. These relatives incorporated local dishes believed to aid delivery and postpartum healing into hospital care. In this way, Nigerian families brought the palliative of care, a core part of traditional medicine, to the heart of hospital birth. In many cases, women combined hospital medicine with herbal mixtures as part of their medical care. This practice was frowned upon by the colonial administration, leading to repercussions against traditional doctors who administered such herbs. Regulations by traditional medical societies also curtailed this simultaneous use of traditional and biomedical drugs. One such society required its doctors to obtain statements from patients indicating that they were not currently receiving treatment from an "English doctor."[319] Since all traditional medical practitioners were not registered with medical associations, these regulations did not completely prevent the simultaneous use of traditional and biomedical prescriptions. Many families continued to utilize local remedies for postnatal healing and recuperation.

Faith Delivery Homes and Modernizing Attempts

Aladura birthing institutions were not exempt from the changes during this era. From their inception, they were subjected to derisions from European administrators for their rejection of biomedicine, which was the central part of *Aladura* doctrine during the

---

319 NAE MINHEALTH 30/1/243, "Native Medicine," 14.

1930s. In the 1940s, however, many *Aladura* churches adjusted their practices to stay attuned to developments in the society. One of the changes emerged from the growing number of educated members in the churches' ranks. The institutions needed to cater to this group of members.

While interviewing faith based midwives and other *Aladura* members, we reflected over the church doctrines against the use of medicine and what this meant for members who desired to pursue training as doctors and nurses. Did it mean that members were barred from these professions? Several individuals pointed out that the churches had such trained professionals in their ranks and in fact utilized their knowledge of biology and anatomy in their practices. This was not always the case. In the early years of the *Aladura* movement, a sizeable amount of the population was uneducated.

The change in their initial approach to medicine started in the 1940s when some *Aladura* church constitutions included prayers for those utilizing medicine. This marked a shift from total rejection to partial embrace of medicine. Prayer books included lines about God's guidance to physicians so that they would administer the right medicines to an ailing member. The older churches, such as Christ Apostolic Church, ceased to condemn the use of medicine by members, but continued to barr such use within the church premises. Their faith delivery homes remained devoid of biomedicine. To appear as modern and stave off much of the condemnation from official circles, as well as appeal to their own membership, the homes embraced technologies of biomedicine.

Faith Homes also forged alliances with trained doctors and nurses, mostly of the same faith, who provided technical assistance, when needed. These medical personnel assisted in actual births and offered physiological trainings to faith based midwives. The training institution for religious-based midwives at Ede reflected these kinds of collaborations. Incorporating training from their own adherents ensured that teachings conformed to church beliefs. These trainings revolved around practical issues like nutritious diets, the female anatomy, dangers associated with pregnancy, and the causes of maternal deaths. While some of the churches worked closely with doctors who took on unmanageable complications, Christ Apostolic Church retained its policy against medicine. One difference from their earlier beliefs was that members could take recourse to biomedicine. It was no longer a sin to do so. Such medicines were not administered inside the church, however.[320] Requirements for childbirth also reflected non-medicinal items common in hospital settings.

320 Moses Adebola Olowe, c.76, Interview, CAC Okeife, November 18, 2015.

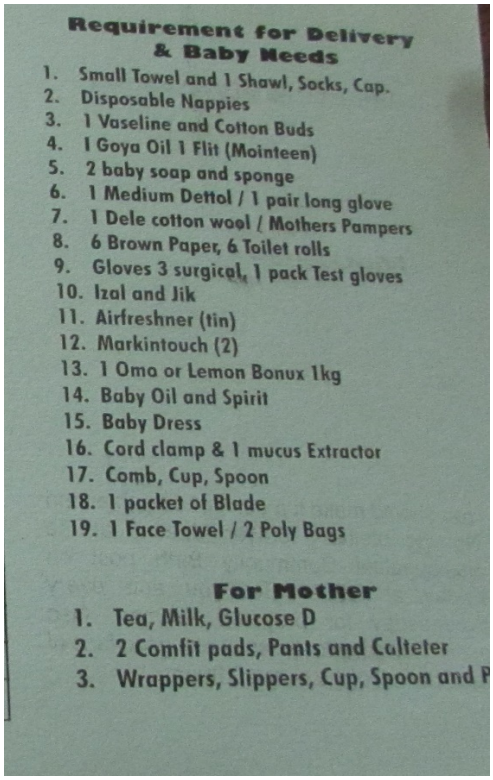

Figure 33: Items required for delivery at a Home in Ibadan

Figure 34: Poster of nutrition for pregnant women, common in *Aladura* Faith Homes since the 1950s

Conclusion

Though they represented various traditions, the three modes of childbirth that existed in Nigeria had their foundations in cultural and religious practices. Colonial midwifery represented western philosophies and had its roots in missionary medicine. Traditional midwifery, on the other hand, was a reflection of traditional values and religious belief systems while Aladura midwifery was a direct result of Christian

missionary presence in Nigeria. Like other forms of midwifery, it was steeped in religion, cultural practices, and local belief systems.

By the 1930s, the two birthing spaces that joined traditional midwifery had established deep roots among the people. However, they did not displace each other. On the contrary, each evolved to stay abreast of developments in the cultural setting and remain relevant in rapidly changing circumstances. This period of involuntary coexistence triggered attempts by traditional medical personnel to professionalize and gain acceptance or legitimacy before potential clients and the colonial government. These attempts did not materialize into a medical organization equateable to biomedicine. The traditional medical societies were, instead, at the mercy of the colonial administration, who tolerated them because they made information about herbs and traditional pharmacopeia readily available to the government.

The organization of traditional medicine went hand in hand with attempts to construct private birthing homes and other permanent facilities from which the traditional midwife practiced. As the politically superior birthing method, hospital birth became the yardstick for other birthing spaces, who adjusted themselves to the existence of colonial maternities. These changes were, however, not restricted to traditional and faith delivery institutions. While colonial maternities made their own adjustments in response to local situations, Nigerians also infused their belief systems within hospital settings, especially as these medical spaces became increasingly manned by locals.

Among rural residents, the stigma that developed against traditional midwifery due to its association with paganism and poverty was less pronounced because of stronger cultural consciousness and the scarcity of colonial medical facilities. Where biomedical services existed, rural residents found ways of integrating traditional and biomedical birthing methods in ways that best suited them. Elements of indigenous practices that fulfilled some social purposes were retained. As a subtle form of resistance and adaptation, the biomedical system was infiltrated by indigenous notions of healing and care. *Aladura* midwifery also desisted from its total rejection of biomedicine to incorporate components that suited them. Notwithstanding, they controlled this interaction with biomedicine to reflect their own beliefs. They also remained anti-traditional medicine, which was associated with witchcraft and paganism.

In conclusion, the account of childbirth and birthing spaces in colonial Nigeria was that of hybridity. The existence of these multiple birthing institutions shaped post-independence maternity practices and offers a framework for addressing Nigeria's high maternal and infant mortality rates. A combined use of the three birthing institutions in this study creates opportunities for the reproductive landscape in Nigeria and points to the usefulness of rural medicine, as developed by traditional, colonial, and religious medical institutions during the colonial era. We now turn to reflections on some of these opportunities and their implications for the contemporary era.

Epilogue

Birth, Maternity, and the Nation in the Postcolonial Era

Towards Independence and Beyond

Since the 1940s, emphasis on healthcare focused on reducing maternal and infant mortality rates. British colonial policies targeted the general improvement of health. By Nigeria's independence in 1960, dialogues among western powers, for instance Britain and the United States, shifted towards birth control for developing nations. The focus of intervention initiatives now moved from infant mortality rates to a birth control politics that endured beyond the twentieth century.

Conversations about population control for Nigeria began during the 1930s and was connected to the population crises in India, a British colonial territory. Corporations in the United States, such as the Carnegie Corporation and the Rockefeller Foundation, spearheaded much of these discussions.[321] British administrations, while providing some financial support for these attempts, observed that, despite overcrowding in urban areas, the African continent had room for population expansion. They recognized the importance of children as economic investments in the continent. Britain also understood that birth control attempts would be interpreted by many Africans as "a trick by the white

321 BNA CO 859/62/17, Birth Control West Africa, 1.

race to destroy the colored peoples."[322] Success was anticipated only among the educated elites; therefore, British officials in Nigeria discouraged any birth control policies.[323]

From independence in the 1960s, however, the push for population control reemerged again and occupied health intervention efforts, moving attention from mortality rates within the former colony. In support of such a shift, a British official had observed that the population of African countries were bound to increase as standards of living improved. This increase, he observed, occurred at a time when the population of many European countries, except the USSR, was declining.[324] The shifts towards population control minimized concerns about mortality and instead focused attention on the economics of childrearing. It was not until the 1970s and 1980s that global attention became drawn once more towards maternal and child mortality rates.[325]

One of the problems with childbirth and reproductive health during this period was that the independence government did not prioritize maternal health institutions nor preventive medicine. The privileging of doctors and government hospitals, which were mostly located in urban centers, over rural health centers, dispensaries, and maternity

---

[322] Ibid., 2.

[323] Ibid.

[324] Ibid., 3

[325] This period marked the introduction of international maternal health programs, such as Safe Motherhood.

homes affected the provision of maternity services to populations in many rural areas.[326] Doctors with private clinics also concentrated their practices in the more lucrative cities, largely neglecting rural areas. Aspects of healthcare services that tended to rural areas, such as dispensers and public health assistants (sanitary inspectors) were phased out.

These trends were compounded by the federal government's noncommitment to healthcare initiatives at all levels. Both state and federal governments failed to fill the gap left by the colonial government in championing maternal and infant health policies.[327] This government ineptitude is connected to Nigeria's political climate after independence, in which the country fell to military dictatorships and only had its first consistent democratic rule from 1996. The logic here is not that democracy is somehow tied to good healthcare. Rather, it is that political stability enables the sustenance of health and other related policies.

Currently, federal and state governments in Nigeria hardly see the problem of maternal and infant welfare as a national issue. As a result, international interventions geared towards improving reproductive health are just that – foreign interventions. Government has no direct responsibility towards such initiatives and, therefore, do not

---

326 RAC FF R6306 089009870000, *Ford Foundation Grant File*, PA 890-0987, 3.

327 Some of these challenges are pointed out in RAC FF R3879 081500620000, *Ford Foundation Grant File*, PA 81-62, 3 where some of Nigeria's health challenges since independence are discussed.

see their goals as a national responsibility. These programs, thus, wither as soon as their sponsors withdraw. They are also devoid of any political will from the population in the recipient country. Despite government pledge to the United Nation's Millennium Development Goals (MDGs), the fifth of which was to reduce maternal and infant mortality ratios, government efforts have been meagre, and less than 4 percent of the national budget is allocated to health care.[328] Under these conditions, attempts made at controlling maternal mortality rates in the country remain insufficient.

Where government interest in maternal health has been galvanized at the local level, success has been recorded. An example of such effort exists in Ondo State in Southwestern Nigeria, where the state governor launched *Abiye* (born to survive), a maternity project aimed at improving maternal and infant health outcomes. The *Abiye* project involved the establishment of hospitals, dedicated to addressing maternity and child welfare issues.[329] These hospitals, named Mother and Child Hospital, offered free healthcare for pregnant women and children under the age of five. of the *Abiye* project utilized a tactic – mobile medicine – that was adopted in the colonial era for health

---

328 *Millennium Project*, Available: http://www.unmillenniumproject.org/goals/gti.htm#goal5. Accessed: March 20, 2017

329 "World Band Lauds Ondo Governor Over Safe Motherhood Project," Available: http://www.ondostate.gov.ng/press_release/WORLD%20BANK.pdf, accessed March 20, 2017.

propaganda and care. Paramedics brought healthcare and education to people's door steps.[330] The project increased hospital births from 16 percent to 35 percent in the state.[331] The success recorded by this locally implemented Safe Motherhood program points to the importance of rallying local support and investments in such efforts.

The strides made by the Ondo project bring to the fore the central argument inherent in this work: all birthing methods in Nigeria offer one or other advantages. Understanding and merging these benefits provides tremendous opportunities for childbirth in Nigeria. The technique adopted by the Ondo State governor, Dr. Olusegun Mimiko, is not novel. The adoption of mobile medical care and homebased care for expectant mothers was practiced by the colonial administration and traditional midwives. Nigeria must prioritize preventive medicine and healthcare in general, and adopt a healthcare delivery system that works for their circumstances. Maternal health, especially in rural communities, must not follow a set pattern according to biomedical practices. The healthcare system will benefit from a remodeling based on combined biomedical, traditional, and faith based approaches.

---

330 *All Africa Online News,* "Nigeria: Ondo State Governor Determined To Turn Tide On Maternal Health," Available: Http://Allafrica.Com/Stories/201301181530.Html

331 "World Band Lauds Ondo Governor Over Safe Motherhood Project," Available: http://www.ondostate.gov.ng/press_release/WORLD%20BANK.pdf, accessed March 20, 2017.

Attempts to improve traditional birthing practices have come, not from indigenous efforts, but largely through initiatives by international organizations. One of such attempts came through the Safe Motherhood initiatives launched across developing countries in 1987. These programs introduced trainings and workshops for traditional midwives, and popularized the term, Traditional Birth Attendant (TBA). TBA applied not just to existing midwives but a new set of women (trained or untrained) who took advantage of the Safe Motherhood programs and acquired certificates with which they practiced midwifery. Without, local and national government investment in these programs, they will continue to lack sustainability and political will to succeed. Local governments could imitate the efforts by traditional healers in the colonial period to professionalize their care. They could create a safe motherhood program that provides uniform training for traditional midwives while simultaneously instituting technological and other aspects of contemporary healthcare that would promote traditional midwifery. Such a development would receive more support and investment from the people.

Considering the inadequacy of health facilities in rural areas, transport systems and networks need to be created between traditional midwives and their hospital counterparts in order to ensure good healthcare. The research for this project involved visits to remote rural areas in attempts to locate midwives. Transportation to these areas was more than inadequate to the extent that it took miles of trekking to secure any form of transportation from the communities back to the city at the end of my interviews. In one case, I hired a biker, who drove about ten miles to the midwife's destination and

waited to take me back into town. Failure to make these kinds of arrangements meant being stranded. This dilemma brought up a larger issue for me: in the case of emergencies, how did midwives transport their families to the nearest hospital, which was often many miles away? Many of the rural health centers were unmanned and in ruins. These are issues that require government consideration.

Traditional and Religious Midwives' Progress: Obstacles

As students at a School of Midwifery in Enugu discussed the challenges of contemporary midwifery in Nigeria, I listened with interest. One issue that was prominent in this discussion, as well as others, was that more successful interventions would be made if traditional and faith-based midwives referred emergencies and other difficult births to hospitals in a timely manner. "Some of the mortality rates we have in these hospitals are not attributable to the hospital," one midwife stated. "These TBAs do not refer patients until all is lost and they know that the patient will die. The patient dies upon arrival to the hospital and such demise enters the hospital records while the midwife, especially the faith based ones, claim little or no casualty."[332] Early referral is, therefore, a major issue. Among all the faith based midwives that I interviewed, only two opened up about mortality issues in their practices. For others, this was a subject that could not be

---

332 Group Interview Session at ESUT School of Post-Basic Midwifery, Enugu, April 6, 2016.

broached. They refused to acknowledge any fatalities. One mentioned a death but emphasized that this client died in the hospital and not at the church facility. The midwives' unwillingness to confront mortality weakens the prospect of referrals. It is here that local and state government efforts to bridge the gap between these medical practices and mainstream medicine could become effective.

A hybrid system already exists where pastors and other ministers attend to the spiritual aspects of patients' healing while hospitals take care of the physical. What needs to be invested in is a deliberate policy by national, state, and local governments to create and support these partnerships. One major challenge to these partnerships is the tendency, inherited from colonial attitudes, to marginalize "alternative" forms of birth as inefficient, classless, and spiritually unclean. These attitudes have bred a sense of superiority among biomedical healthcare professionals, and created animosities between the various medical divides, making partnership untenable. Educational institutions have to reeducate and inculcate in medical students and staff the importance of traditional medical systems and their value in overall healthcare provision.

The inefficient administration of local herbs represents another concern voiced by healthcare workers who lamented that the simultaneous use of herbal and hospital prescriptions may interact negatively. This challenge does not apply only to midwives or patients but also hospitals. Many hospitals do not take records of patient's current medications. This circumstance could be ameliorated if doctors routinely acquired patient's substance history before prescribing treatments. Traditional gynecologists and

midwives, on the other hand, need to also take note of patient's use of alternative medications. Perhaps the rule by earlier local medical societies, wherein they required a practitioner to inquire if a patient was undergoing hospital treatment and was under medications, could be beneficial here.

A system that incorporates local culture and all levels of local government as the background for its healthcare is important. This will create a political and social climate conducive to a syncretic birthing program. Biomedical forms of birth cannot continue to be overlooked by the government. In places where regulations have been lacking, the practices have cost lives. In others where the focus is on harassments and marginalization, these local practices have been undermined. Such harassments showed during my field work. Traditional midwives and other women in Ibadan communities were reluctant to speak with me about midwives or how to locate them. Later, it was explained that they were subject to police raids and arrests for varying charges. On the other hand, government-monitoring of the affairs of traditional and faith based midwives resulted in efforts by these centers to keep their centers in good condition. *Aladura* midwives in Ibadan mentioned regular and sometimes random government checks on their facilities.

Local birthing methods (traditional and faith-based) remain popular in various parts of the country due to their affordability and flexibility. There are much prospects here, and government needs to rediscover the potency of the media in molding public opinion. International organizations utilized plays, television shows, and music

throughout the 1980s and 1990s to shape reproductive habits. Popular artists like Onyeka Onwenu and Sunny Ade were recruited to perform songs on family planning and abstinence.[333] In an environment where young people pay significant attention to the media, this tactic, if utilized, will reach tremendous amounts of people.

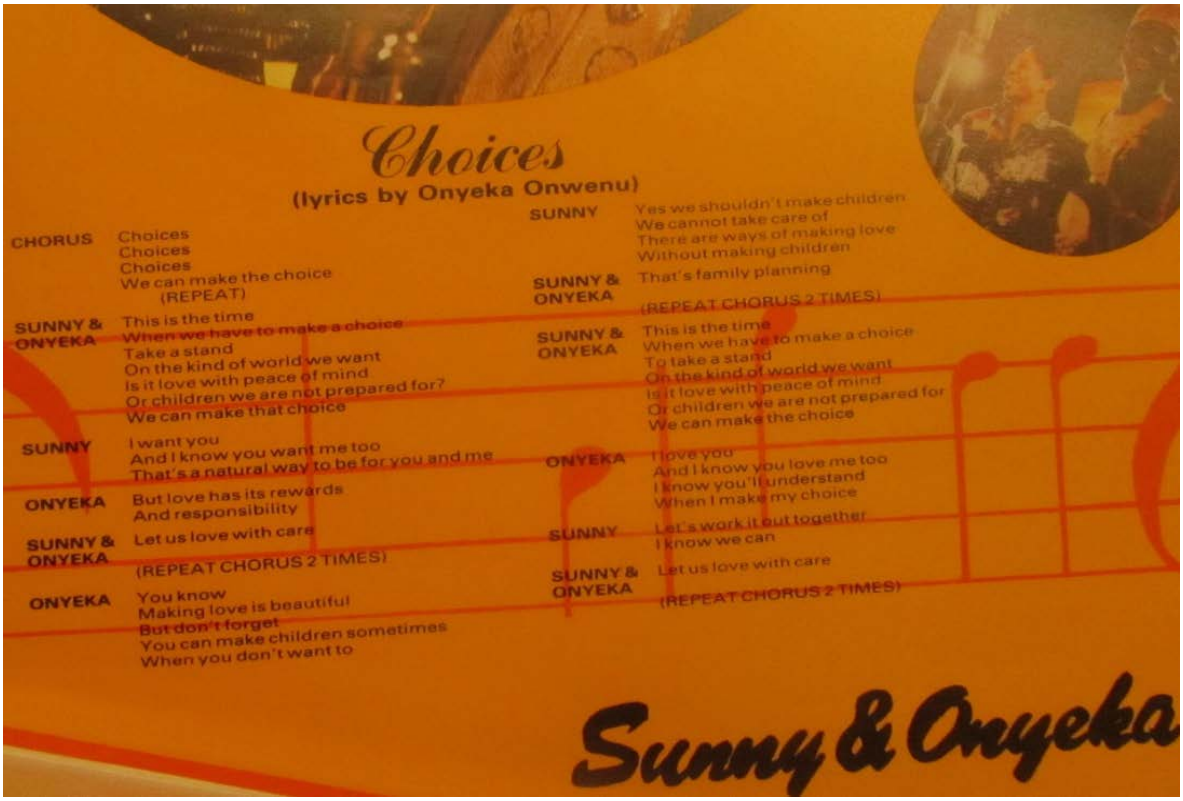

Figure 35: Lyrics of a song aimed at birth control propaganda produced and distributed by Planned Parenthood Nigeria[334]

---

333 WL 7720600

334 Ibid.

The most important thing in this narrative remains that the national, state, and local governments need to prioritize health and get involved actively in safe motherhood initiatives. Existing programs funded by international and non-governmental organizations can never be as effective without the active participation of the national government. The budget allocation on health also needs to be increased dramatically in order to tackle the health disparities that exist in the country, especially in the Northern region. More noteworthy, the knowledge of a local population's medical traditions and taboos is a necessity in the successful propagation of any health education.

Bibliography

Primary Sources

Archival Materials

Nigeria:

National Archives, Enugu

NAE MINHEALTH 30/1/253, *Medical development in Nigeria.*

NAE MINHEALTH 6/1/22, *CMS Midwifery Training School, Ref. No. E.1.21/34.*

MINHEALTH 30/1/243, "Native Medicine."

National Archives, Ibadan

OYO PROF 1/1129, *Domestic Training for Girls-Suggestions as to.*

J/1/a, *Medical Policy in the Colonial Empire.*

CSO 26/3, *Infant and Maternity Work in Nigeria II.*

MH (FED)/1/1/4075, *Infant Welfare Center, Ondo Province*

OYO PROF 1 662, *The Faith Healer-Babalola and the Faith Tabernacle otherwise known as The Aladura Religious Movement-Operation of in Oyo Province*

OYO PROF 1/28, *Aladura Movement (Apostolic Church)*

OYOPROF 105/1921, *Native Herbal Medicine Dealers: Practice and Sale of Herbal Preparations*

Britain:

British National Archives, Kew

CO 583/248/6, Mission Activities "African Missions", *Training of Subordinate Staff in the Medical Department.*

DV 12/68, *Nigeria: Lagos Island Maternity Hospital*, 1959, 3.

CO 859/62/17, Birth Control West Africa.

Cadbury Research Library, Birmingham

ACC 444/Z1/1, *Map of Nigeria.*

M/F1/ N1/1, *Iyi-Enu*.

ACC 444/Z1/35, *Baby Show*.

CMS G/3/A/9/

Mercy and Truth: The Record of Medical Missions of C.M.S., (Several volumes).

Medical Missions Quarterly, Nos IX to XVI, London: Church Missionary Society, Salisbury Square, E.C.

CMS M/C 2/1/7 (1898-1905).

The Mission Hospital: A Record of C.M.S Medical Missions (Several Volumes).

M/Y/A3/1, 1916-1933, "Extract from the Letter from Archdeacon Basden to Rev. H.D. Hooper, dated, Onitsha, July 29, 1932.

ACC 716/F8, *Church Missionary Outlook* (Several Volumes).

G/Y/A/9/2, *G.T.M, Northern Nigeria Missions.*

ACC 594/01, *Northern Nigeria Mission, Mission Policy in Hausaland*.

CMS ACC 780/F1, *Dorothy Ross, The Pattern of a Life.*

CMS ACC/165/F27, *The Private Owned Maternity Home in Nigeria.*

M/M3/3/1942/3, *Medical Mission, Wusasa, Zaria.*

CRL H7/B/6/5/14.

H7/B/7/80, *Africa, Mainly about Women in the Church of the Lord*.

H7/B/51/2/55.

H7/B/4/2/101, *Ecumenical Review*, "On Christ Apostolic Church."

H7/B/7/2, *West Africa*.

H7/B44/126, *The Rules and regulations Observances and the Constitution of the New Salem Holy Saviour's Church (Aladura).*

H7/B/51/2/54, *An Address Entitled 'Facts about Faith, Psychic, or Spiritual Healing,' delivered by Dr. E.O.A. Adejobi, the Primate of Church of the Lord (Aladura).*

H7/B/51/1/96, *The Ladies Praying Union, Its Rules and Regulations.*

H7/B/51/3/21, *Nigeria.*

Wellcome Library, London

CO 593, Southern Nigeria, No. 39 of 1908.

ANN REP WA28 NH5 N68 1922-1928, *Annual Medical and Sanitary Report.*

AC 149, *Annual Report of the Ministry of Health and Social Welfare*, 1958.

H1B 948, *Annual Report of the Federal Medical Service, 1958.*

7720600.

Royal Commonwealth Society Library, Cambridge

CMS MED 1382, *Entrance to Iyi-Enu Hospital.*

The Weston Collection, Nursing in West Africa Slides.

Rockefeller Archive Center, New York

RAC FF R2756 081500620000, Ford Foundation Grant File.

RAC FF R3879 081500620000, Ford Foundation Grant File.

RAC FF R6306 089009870000, Ford Foundation Grant File.

National Museum, Enugu

Selected Interviews

Ibadan

Elder Moses Adebola Olowe, November 18, 2015.

Comfort Aliko, Ibadan North.

Prophetess Olaniyi, Ibadan, November 23, 2015.

Interview with Ademola Saheed on behalf of Duratola Abimbola November 15, 2015.

Mrs. Adeyekpa, November 25, 2015.

Pastor Mrs. Beatrice Okiola, November 19, 2015.

Lagos

Midwife Oluwaleye Ara, March 22, 2016

Pastor E.O.T. Olorunwa, March 23, 2016.

Group Interview with registered pregnant women at Odi Olowo Faith Home, Lagos, March 23, 2016.

Enugu

Chizoba, April 9, 2016.

Ogidija Ugwuole, April 5, 2016.

Onyeugwu Ogwo, April 6, 2016.

Makata Eze, Interview, March 28, 2008.

Nnanna Okorom, Interview, March 2, 2011.

Ngozi Ikwueze, April 2, 2016.

Chukwuma Opata, April 8, 2016.

Felicia Eze, April 2, 2013.

Mary Ugwuanyi, June 26, 2013.

Group Interview with Nursing and Midwifery Students, April 9, 2016.

Lolo, April 6, 2016.

Anambra

Ezechikwelu, May 4, 2016.

Philip Nnatu, April, 2016.

Rosaline Ezekwem, March 28, 2016.

Amalugo Chibuzo, April 10, 2016.

Nurse Obeledu March 27, 2016.

Secondary Sources

Abugideiri, Hibba. *Gender and the Making of Modern Medicine in Colonial Egypt.* Vermont: Ashgate Publishing, 2010

Ade Ajayi, J. F. K. *Christian Missions in Nigeria: The Making of a New Elite, 1841-1891*. London: Longman 1965.

Addae, Stephen. *History of Western Medicine in Ghana 1880-1960.* Edinburg: Durham Academic Press, 1997.

Adekson, Olufunmilayo Mary. T*he Yorùbá Traditional Healers of Nigeria*. New York: Routledge, 2003.

Agbasiere, Joseph. *Women in Igbo Life and Thought*. London: Routledge, 2000.

Agyei, Mensah, Samuel and Johnson B. Castreline (eds.) *Reproduction and Social Context in Sub-Saharan Africa: A Collection of Micro Demographic Studies*. Connecticut: Greenwood Press, 2003.

Airhihenbuwa, Collins. *Health and Culture: Beyond the Western Paradigm*. California: Sage Publishers, 1995.

Allman, Jean Marie, Susan Geiger, and Nakanyike Musisi. *Women in African Colonial Histories*. Bloomington: Indiana University Press, 2002.

Amadiume, Ifi. *Male Daughters, Female Husbands: Gender and Sex in an African Society*. London: Zed Books, 1987.

Amba, Mercy and Musimbi Kanyoro. *The Will to Rise: Women, Tradition, and the Church in Africa*. New York: Orbis Books, 1992.

Appiah-Kubi, Kofi. *Man Cures, God Heals: Religion and Medical Practice Among the Akans of Ghana*. Totowa, NJ: Allanheld, Osmun, 1981.

Arnold, David. *Imperial Medicine and Indigenous Societies.* Manchester: Manchester University Press, 1988.

Ayandele, E.A. *The Missionary Impact on Modern Nigeria 1842-1914: A Political and Social Analysis.* London: Longman, 1966.

Baranov, David. *The African Transformation of Western Medicine and the Dynamics of Global Cultural Exchange.* Philadelphia: Temple University Press, 2008.

Bascom, William. *The Yoruba of Southwestern Nigeria*. New York: Holt, Reinhart, and Winston, 1969.

Basden, George. *Among the Ibos of Nigeria*. Gloucestershire: Nonsuch Publishing Limited, 2006.

Beidelman, T.O. *Colonial Evangelism*. Bloomington: Indiana University Press, 1981.

Blakely, T.D et al (eds.). *Religion in Africa: Experience and Expressions.* London: James Currey, 1994.

Boahen, Abu. *African Perspectives on Colonialism.* Baltimore: John Hopkins University Press, 1987.

Boggs, Belle. *The Art of Waiting: On Fertility, Medicine, and Motherhood.* Minnesota: Graywolf Press, 2016.

Booker, B. *Traditional Birth Attendant Training, Manicaland.* Zimbabwe: Mutare, 1983.

Bourbonnais, Nicole. *Birth Control in the Decolonizing Caribbean: Decolonizing Politics and Practice on Four Islands, 1930-1970*. Cambridge: Cambridge University Press, 2016.

Buckley, Anthony. *Yoruba Medicine*. Oxford: Clarendon Press, 1985.

Burke, Timothy. *Life Buoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe.* North Carolina: Duke University Press, 1996.

Callaway, Barbara. *Muslim Hausa Women in Nigeria: Tradition and Change*. Syracuse: Syracuse University Press, 1987.

Chalmers, Beverly. *Childbirth in Cultural Transition*. South Africa: Berev Publications, 1990.

Chuku, Gloria. *Igbo Women and Economic Transformation in Southeastern Nigeria, 1900-1960.* New York: Routledge, 2005.

Coles, Catherine and Beverly Mack (eds.). *Hausa Women in The Twentieth Century*. Madison: University of Wisconsin Press, 1991.

Comaroff, John and Jean Comaroff. *Ethnography and the Historical Imagination*. Boulder, CO: Westview Press, 1991.

Comaroff, Jean. "Medicine and Culture: Some Anthropological Perspectives." *Social Science and Medicine*. Vol. 12b (1978): 247-54.

Connor, Linda and Geoffrey Samuel (eds.). *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies*. London: Bergin & Garvey, 2001.

Cooper, Frederick. *Tensions of Empire: Colonial Cultures in a Bourgeois World*. Berkeley, CA: University of California Press, 1997.

Cooter, R. *Studies in the History of Alternative Medicine*. Houndsmill: Macmillan, 1988.

Coquery-Vidrovitch, Catherine. *African Women: A Modern History.* Boulder, CO: Westview Press, 1997.

Cosslet, Tess. *Women Writing Childbirth: Modern Discourses of Motherhood.* Manchester: Manchester University Press, 1994.

Davin, Anna. "Imperialism and Motherhood. *History Workshop*." Vol. 5 (1978): 25-28.

Ehrenreich, John, ed. *The Cultural Crisis of Modern Medicine.* New York: Monthly Review Press, 1978.

Ekechi, F. K. *Missionary Enterprise and Rivalry in Igboland 1857-1914.* London: Frank Cass, 1971.

Elling, Ray H. *Cross-National Study of Health Systems: Political Economics and Health Care*. New Brunswick: Transaction Books, 1980.

Falola, Toyin and Nana Amponsah (eds.). *Women, Gender, and Sexuality in Africa.* Durham: Carolina Academic Press, 2012.

Falola, Toyin and Matthew Heaton (eds.). *Health Knowledge and Belief Systems in Africa.* Durham: Carolina Academic Press, 2008.

Feierman, Steven and John Janzen. *The Social Basis of Health and Healing in Africa*. California: 1992.

Ferngren, Gary. *Religion and Society in Nigeria: Historical and Sociological Perspectives*. Baltimore: Johns Hopkins University Press, 2014.

Fieldes, Valerie. Lara Marks, and Hilary Marland (eds.). *Women and Children First: International Maternal and Infant Welfare, 1870-1945*. London: Routledge, 1992.

Fletcher, Jeannine. *Motherhood as Metaphor: Engendering Interreligious Dialogue*. New York: Fordham University Press, 2013.

Flint, Karen. *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948.* Ohio: Ohio University Press, 2008.

Gelfand, Michael. *Midwifery in Tropical Africa: The Growth of Maternity Services in Rhodesia.* Salisbury: University of Rhodesia, 1978.

Gemi-Iordanou, Effie, Stephen Gordon, Robert Matthew, Ellen McInnes, and Rhiannon Pettitt (eds.). *Medicine, Healing, and Performance.* Oxford: Oxbow, 2014.

Geurts, Kathryn Linn, "Childbirth and Pragmatic Midwifery in Rural Ghana, Medical Anthropology, 20, 4, (2001): 379-408

Good, Charles. *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya*. New York: The Guilford Press, 1987.

Green, Monica. *Making Women's Medicine Masculine: The Rise of Male Authority in Pre-Modern Gynaecology*. New York: Oxford University Press, 2008.

Grimshaw, Anna. *The Ethnographer's Eye: Ways of Seeing in Anthropology.* Cambridge: Cambridge University Press, 2001.

Handwerker, W.P. (ed.). *Birth and Power: Social Change and the Politics of Reproduction.* Colorado: Westview Press, 1990.

Hardy, Sarah and Caroline Wiedmer (eds.). *Motherhood and Space: Configurations of the Maternal through Politics, Home, and the Body*. New York: Palgrave Macmillan, 2005.

Harneit-Seivers, Axel. *Constructions of Belonging: Igbo Communities and the Nigerian State in the Twentieth Century*. New York: University of Rochester Press, 2006

Hastings, Adrian. *Church and Mission in Colonial Africa*. London: Burns and Oates, 1967.

Hardiman, James (ed.). *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa.* New York: Rodopi, 2006.

Holloway, Kris. *Monique and the Mango Rains: Two Years with a Midwife in Mali.* Waveland Press, Inc., 2006.

Hunt, Nancy Rose. *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo.* Duke University Press, 1999.

_____. "Le Bebe en Brousse: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo." *International Journal of African Studies*. Vol. 21 (1988): 401-32.

Isichie, Elizabeth. *The Ibo People and the Europeans.* London: Faber and Faber Limited, 1970.

_____. *A History of the Igbo People.* London: The Macmillan Press, 1976.

_____. *Igbo Worlds: An Anthology of Oral Histories and Historical Descriptions.* Philadelphia: Institute for the Study of Human Issues, 1978.

_____. *A History of Nigeria.* London: Longman, 1983.

Imperato, Pascal. *African Folk Medicine.* Baltimore: York Press Inc., 1977.

Jacobson, Jodi. *Challenge of Survival: Safe Motherhood in the SADCC Region*. New York: Family Care International, 1991.

Janzen, John. *The Social Fabric of Health*. An Introduction to Medical Anthropology. Boston: McGraw Hill, 2002.

Jett, J. *The Role of Traditional Midwives in the Modern Health Sector in West and Central Africa.* Washington DC: US Agency for International Development, 1977.

Johnson-Hank, Jennifer. *Uncertain Honor: Modern Motherhood in an African Crisis.* Chicago: University of Chicago Press, 2005.

Kaler, Amy. *Running After Pills: Politics, Gender, and Contraception in Colonial.* Zimbabwe. Portsmouth: Heinemann, 2003.

Kleinman, Arthur. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, 1980.

Korieh, Chima and Ralph Chijioke Njoku. *Missions, States, and European Expansions in Africa.* New York: Routledge, 2007.

Koss-Chioino, Joan, Thomas Leatherman, and Christine Greenway (eds.). Medical Pluralism in the Andes. London: Routledge, 2003.

Langwick, Stacey. *Bodies, Politics and African Healing: The Matter of Maladies in Tanzania.* Indiana: Indiana University Press, 2011.

Last, Murray et al. *The Professionalization of African Medicine.* Manchester: Manchester University Press, 1986.

Charles Leslie and A. Young (eds.). *Paths to Medical Knowledge*. Berkeley: University of California Press, 1992.

Lesthaeghe, Ron. J (ed.). *Reproduction and Social Organization in Sub-Saharan Africa.* Berkeley: University of California Press, 1989.

Lewis, Jane. *The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939*. London: Croom Helm, 1980.

Levine Philippa (ed.). *Gender and Empire*. Oxford: Oxford University Press, 2004.

Loustaunau, Martha and Elisa J. Sobo, *The Cultural Context of Health, Illness, and Medicine* Westport: Bergin and Garvey, 1997.

Maglacas, Mangay-Maglacas A. and John Simons. *The Potential of the Traditional Birth Attendant.* Geneva: World Health Organization, 1986.

Makinde, M. Akin. *African Philosophy, Culture, and Traditional Medicine. Athens.* Ohio: Ohio University Center for International Studies, 1988.

Marks, Shula. *Divided Sisterhood: Race, Class and Gender in Southern African Nursing Profession*. Witwatersrand, 1994.

Martin, Emily. *The Woman in the Body: A Cultural Analysis of Reproduction.* Boston: Beacon Press, 1989, c1987.

Mathews, Holly F. "Doctors and Root Doctors: Patients Who Use Both." In *Herbal and Magical Medicine: Traditional Healing Today*, edited by James Kirkland, et al, 68-98. Durham: Duke University Press, 1992.

McClintock, Anne. *Imperial Leather: Race, Gender, and Sexuality in the Colonial Conquest*. New York: Routledge, 1995.

Mukharji, Projit. *Doctoring Tradition: Ayurveda, Small Technologies, and Braided Sciences*. Chicago: The University of Chicago Press, 2016.

Nasah, B.T., J.K.G. Mati and J.M. Kasonde. *Contemporary Issues in Maternal Health Care in Africa.* Luxembourg: Hardwood Academic Publishers, 1994.

Nzegwu, Nkiru. *Family Matters: Feminist Concepts in African Philosophy of Culture.* Albany: State University of New York Press, 2006.

Oakley, Ann. *Essays on Women, medicine, and Health.* Edinburgh: Edinburgh University Press, 1993.

Obermeyer, Carla Makhlouf (ed.). *Cultural Perspectives on Reproductive Health*. New York: Oxford University Press, 2001.

Olupona, Jacob and Toyin Falola. *Religion and Society in Nigeria: Historical and Sociological Perspectives.* Ibadan: Spectrum Books Ltd., 1991.

Osseo-Asare, Abena. *Bitter Roots: The Search for Healing Plants in Africa.* Chicago: The University of Chicago Press, 2014.

Oyewumi, Oyeronke. *Gender Epistemologies in Africa: Gendering Traditions, Spaces, Social Institutions, and Identities.* New York: Palgrave Macmillan, 2010.

Patton, Adell. *Physicians, Colonial Racism, and Diaspora in West Africa.* Gainesville: University Press of Florida, 1996.

Peek, Philip. *Twins in African and Diaspora Cultures: Double Trouble, Twice Blessed*. Bloomington: Indiana University Press, 2011.

Peel, J.D.Y. *Aladura: A Religious Movement among the Yoruba.* London: Oxford University Press, 1968.

Porter, Roy (ed.). *The Popularization of Medicine, 1650-1850*. London: Routledge, 1992.

Pretorius, H.L. *Historiography and Historical Sources regarding African Indigenous Churches in South Africa: Writing Indigenous Church History.* Lewisten: E. Mellen Press, 1995.

Quaye, Randolph. *Underdevelopment and Health Care in Africa: the Ghanaian Experience*. New York: Edwin Mellen Press, 1996.

Ranger, Terence. *The Invention of Tradition in Colonial Africa*. in *The Invention of Tradition*, edited by Eric Hobsbawm and Terence Ranger. New York: Cambridge University Press, 1983.

Rasmussen, Susan J. *Those who Touch: Tuareg Medicine Women in Anthropological Perspectives.* Dekalb: Northern Illinois University Press, 2006.

Riedmann, Agnes. *Science that Colonizes: A Critique of Fertility Studies in Africa.* Philadelphia: Temple University Press, 1993.

Rhodes, Rosamond, Margaret P. Battin, and Anita Silvers (eds.). *Medicine and Social Justice: Essays on the Distribution of Health Care*. Oxford: Oxford University Press, 2002.

Sanneh, Lamin. *West African Christianity: The Religious Impact.* London: Allen and Unwin, 1983.

Sargent, C. *Maternity, Medicine, and Power: Reproductive Decisions in Urban Benin*. Berkeley: University of California Press, 1989.

Selin, Helaine and Pamela K. Stone. C*hildbirth across Cultures: Ideas and Practices of Pregnancy, Childbirth and the Postpartum.* London: Springer, 2009.

Shiloh, Ailon. *Faith Healing: The Religious Experience as a Therapeutic Process.* Illinois: Thomas, 1981.

Singer, Philip (ed.). *Traditional Healing: New Science or New Colonialism?* New York: Conch Magazine Limited, 1977.

Stephens, Rhiannon. *A History of African Motherhood: The Case of Uganda, 700-1900.* Cambridge: Cambridge University Press, 2013.

Stevenson, Robert. *Population and political systems in tropical Africa.* New York: Columbia University Press, 1968.

Sujatha, V. and Leena Abraham (eds.). *Medical Pluralism in Contemporary India*. India: Orient Blackswan, 2012.

Summers, Carol. "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925." *Signs*. Vol. 16 (1991): 807.

Sundkler, Bengt and Christopher Steed. *A History of the Church in Africa.* Cambridge: Cambridge University Press, 2000.

Squire, Caroline (ed.). The Social Context of Birth. Oxford: Radcliffe Publishing, 2009.

Talbot, Amaury. *Woman's Mysteries of a Primitive People, The Ibibios Of Southern Nigeria.* London: Cassell and Company Limited, 1915.

Tasie, G.O.M. *Christian missionary enterprise in the Niger Delta, 1864-1918.* Leiden: E.J. Brill, 1978.

Thomas, Lynn. *Politics of the Womb: Women, Reproduction and the State in Kenya*. California: University of California, 2003.

Turner, H.W. *History of an African Independent Church.* Oxford: Clarendon Press, 1967.

Turshen, Meredith (ed.). *Women and Health in Africa*. New Jersey: Africa World Press Inc., 1991.

Ulin, P. R., Good Rappaport, and Anita Spring. *Traditional Healers and Primary Health Care in Africa.* New York: Syracuse University, African Series 35, 1980.

Van Teijlingen, Edwin R., George W. Lowis, Peter McCaffery, Maureen Porter (eds.). *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*. New York: Nova Publishers, 2004.

Vaughan, Megan. *Curing their Ills: Colonial Power and African Illness.* Stanford: Stanford University Press, 1991.

Wall, L. Lewis. *Hausa Medicine: Illness and Well-Being in a West African Culture*. Durham: Duke University Press, 1988.